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THE TREATMENT OF THE PSYCHOTIC-LIKE REGRESSIONS OF THE COMBAT SOLDIER

BY MAJ. WALTER GOLDFARB, M. C., AND LT. COL. HUGH E. KIENE, M. C.

The invasion of Normandy in June, 1944, resulted in an increased number of neuropsychiatric casualties in combat troops. In the installation, dealing solely with NP casualties, in which the writers were serving, they had the opportunity to observe many hundreds of these regression reactions. All the patients received every opportunity for improvement, with the prevalent therapeutic methods of hypnosis, narcosis or modified insulin, or spontaneously with rest. Many patients improved, but because of the nature of this installation the writers have received a large absolute number of the failures. They have no data on the proportion of the failures in therapy to the total number of regressive reactions. The present paper is a report of the response of these severe casualties at the writers' installation to the "shock" therapies.

Case Material*

The patients presented pictures resembling psychoses, or severe regression reactions, and the writers have attempted to treat the cases resistant to other forms of therapy with "shock" treatment. The technique has been described in a previous publication. The various clinical appearances observed are exemplified by the following case histories.

Case 1

The patient was a 21-year-old white man who was first hospitalized with the usual symptoms of anxiety and battle dreams after three days of combat. After a few days in the hospital, he suddenly became stuporous, exhibited catatonic-like flexibilitas cerea, would not respond to noxious stimuli, and, under amytal hypnosis, only murmured a few words before passing into deep sleep. The amytal was repeated on several occasions with the same result.

This man was then treated with two electric shocks and made a complete remission from his catatonic-like behavior. He reported

*Note: Only the percentage of improvements is given. The writers believe the actual numbers are sufficient to warrant the use of this percentage.

that he had been conscious of being stimulated and had been conscious of the presence of the examiner, but had been unable to respond. He was pleasant and cooperative, and had no memory loss. He was sent to the reconditioning wards with a view to returning him to duty, but soon developed a negativistic attitude and a mild paranoid reaction directed toward the officer in charge. He showed mild anxiety and tremors of the extremities. He did not complain of insomnia or battle dreams.

Because of his poor reaction and the fact that he had broken down after only three days of combat, the patient was boarded to the Zone of the Interior. The significant factors in his background were that he had worked only for his father and had never lived away from his family. He had had no sexual experience; and on the whole, his reactions were those of an immature personality.

Comment. At the onset, this reaction type presented the problem of differential diagnosis between a hysteric and an acute psychotic reaction. However, the hysteric nature of the disorder was clearly indicated by the behavior of this type of patient after treatment. In each case, the suggestion that these men return to duty resulted in a resurgence of symptoms of one kind or another which prevented the return. The new symptomatology often took the form of belligerently aggressive behavior, or anxiety, but the writers have not observed a recurrence of the psychotic-like reaction. They do not believe that the fundamental conflict presented to the patient by combat duty had been affected by the electric shock, but rather that the manifestations had changed. The patients were completely cooperative after they had been informed that they were to be transferred to the United States.

Case 2

The patient in Case 2 was a 29-year-old white male with six years of military service. He was a paratrooper, jumped in France on D Day and was in active combat until the first of July, 1944. He was evacuated because of behavior in which he developed paranoid delusions about his fellow-soldiers, and complained of seeing bizarre figures jumping about. In addition, he had insomnia, headache and various phobias.

Narcotherapy for three days and several abreactions under amytal produced no change, and electric shock was recommended. After four convulsions, the patient showed considerable improvement. He was pleasant and cooperative, he displayed no anxiety symptoms and complained only of a mild headache.

In view of this man's fairly good background, and the marked stress of his particular combat experience, it was felt that he could be returned to noncombat duty, and he was discharged from the hospital and returned to duty with a recommendation that he be assigned to a noncombat unit. This patient was sent to the American School Center for training in a mechanical trade. After one week in school, he complained about pains in the back and was returned to the hospital. No organic basis for his complaint could be found, and he was evacuated to the United States.

Comment. Many patients of this type were sufficiently depressed to constitute severe suicidal risks. The hallucinatory experiences and depressions disappeared almost uniformly with electric shock treatment. However, a suggestion that the patient return to duty precipitated new symptoms which successfully prevented such action in almost all of these cases. The writers felt that these reactions were fundamentally psychologic regressions rather than psychotic episodes.

The regressive nature of the amnesic syndrome made it of interest to treat those amnesic patients who were resistant to amytal hypnosis. The following case was typical of this group.

Case 3

This soldier was a 20-year-old white man. He was in combat for five days and gave a history of a nearby explosion having knocked him out. His principal symptom on admission was amnesia, for the period immediately preceding his evacuation and following it, up to the time he was admitted to the hospital. Under amytal narcosis, he expressed very marked paranoid delusions and the amnesic period could not be penetrated. It was felt that he was potentially dangerous. After recovery from the hypnosis, he did not express any paranoid delusions, but his amnesia persisted, and he showed a new development of intense tremors, anxiety and various phobias.

The patient was treated with electric shock and, after two convulsions, completely recovered his memory for his combat experiences and seemed to be in good control of himself. After a period of a week on the rehabilitation ward, he began to complain about headache and stomach pains, became very anxious and expressed some paranoid ideas. In view of the fact that his combat experience was very short before his breakdown, and in view of the severity of the manifestations, it was recommended that he be returned to the Zone of the Interior.

Comment. Amnesias were usually confined to the periods immediately preceding the evacuations of the patients from the front and the evacuations to England themselves. The patients would usually state that they woke up in the hospital. There was a frequent history of unconsciousness following a nearby explosion, and it was difficult to differentiate between possible concussion and the amytal narcosis received in other hospitals. In many instances, concussion was considered minor, since the patients' memories could be restored by hypnosis, or electric shock. The cases which were resistant to hypnosis, would often respond to electric shock treatment.

The factor of malingering (conscious exaggeration of symptoms) was always present, and one patient admitted that his amnesia was feigned. The following case exemplifies those in which it was felt that malingering was a possible factor.

Case 4

This man was 26 years old, white, and with one year of military service. While he was in France, he was captured by members of the French resistance movement who thought that he was a spy. He was confused and could not give an adequate account of himself. He was picked up by English medical aid men on July 27 and stated that he could not remember his outfit, the name of his C. O., etc. He was evacuated to England and, in a hospital previous to his admission to the writers' installation, he experienced auditory hallucinations of God's voice.

When seen in the writers' hospital, he was bewildered and dazed and seemed to have only a tenuous hold on reality. He stated that he had difficulty in thinking and that he was hearing God's voice

constantly telling him what to do. Orientation and memory were poor. He remained in this hospital essentially unchanged for 10 days and was then transferred to the treatment ward for electric shock.

The man was seen the next day, before treatment had been begun, and his entire clinical appearance had changed. He was alert and cooperative. He said his memory had suddenly returned the previous afternoon, and he was able to give a completely accurate account of his recent and remote experiences. He stated that he remembered that he had been hearing God's voice and that this symptom had also disappeared suddenly. He was transferred to a rehabilitation ward with a view to return to duty and took part in the program creditably.

Comment. There was a single instance in which the patient frankly admitted that he had simulated amnesia in order to be returned to the Zone of the Interior. In the remainder of the amnesic patients who recovered suddenly, the factor of fear of the treatment and the comments of the patients who were under treatment undoubtedly played a part in the sudden recoveries. The writers believe that the symptoms were not entirely on a conscious level, because there were associated psychotic symptoms in the form of hallucinations or retardation, which are not part of the average soldier's conscious concept of "insanity" or amnesia. The therapeutic aim of improvement before the soldier became fixated on his symptomatology had been achieved, however, although it is true that the effective agent might well have been the threat of the unknown "electricity machine."

Case 5

This soldier was a 20-year-old white male with a year and four months of service. He was in combat for less than 10 days and was evacuated after being injured by shrapnel. He asserted that he did not remember being evacuated from France, and that he awoke in a hospital in England. While his wounds were healing, he became irritable and had bizarre dreams of being pursued by gray-clad men with knives. He also exhibited fairly marked paranoid delusions related to the personnel of the hospital, and he was transferred to the writers' installation.

When he arrived there, he was tense, irritable, got into a number of fights on the ward and was a serious problem in ward management. This man gave a history of life-long psychopathic behavior, characterized by frequent fights, nomadism, and civil and military arrests. He was treated with five electric shocks and showed a completely changed behavior pattern. The tension and irritability disappeared and he no longer had hypnagogic visual hallucinations.

When the suggestion was made that he return to duty, this patient was definitely antagonistic to the idea. In view of his personality, it was felt that he had a poor prognosis, and he was evacuated to the Zone of the Interior.

Comment. Regression syndromes of various types were noted in patients who were fundamentally constitutional psychopaths. Their combat experiences were usually less than two weeks. The presenting symptomatology disappeared rapidly with electric shock, but it was felt that they would be of little value in the army in the European theater, and they were returned to the Zone of the Interior.

Results

Most of the patients with such severely incapacitating symptomatology as that described in the foregoing case reports were treated with electric shock, and a few were treated with insulin "shock." In every case, amytal hypnosis had failed. The "shock" therapies produced improvement in approximately 90 per cent.

Discussion

The present writers have had the opportunity of observing the various mechanisms of defense against the combat experience of the army, and since their installation received patients after they were screened in other hospitals, the psychological reactions were necessarily the extremely incapacitating ones. In many cases, the psychodynamics were not demonstrable in the short time available for examination and treatment. The writers, however, have identified the following psychodynamic mechanisms in various patients of the present group of severe reactions, listed roughly in

the order of frequency: repression (amnesia), conversion, regression, projection and depersonalization, catatonic states, hysterical stupors and ambivalence.

The presenting symptomatology was often difficult to distinguish from the various psychotic entities. The reactive nature of the symptoms was best observed in the combat cases. When it was suggested that a soldier return to duty after his symptoms cleared with treatment, other types of defense mechanisms appeared which effectively prevented such a disposition. These often took the form of aggressive paranoid tendencies, suicidal ideas, or neurotic complaints of the somatic variety. In most instances, the writers have felt that the patients could not adjust to the military situation in the European theater, and, as therapists, were content with the removal of the incapacitating symptoms before fixation occurred.

The presenting symptomatology of the combat neuroses has long been known to be very variable, and the fact that the symptom groups have resembled various clinical entities has produced considerable confusion in diagnosis and treatment. Kringer and Spiegel (1943) have emphasized this factor in their excellent description of these syndromes. A few cases which presented the typical history of insidious onset of psychosis and a fairly constant symptomatology also showed the following distinguishing characteristics: Prolonged treatment was required to produce remissions; they rarely exhibited anxiety; and they almost uniformly expressed a willingness to return to duty.

In most cases, there was usually ample evidence in the patients' histories that at previous installations the picture presented was different, and usually consisted of severe anxiety symptoms. In addition, after treatment and the removal of the presenting picture in combat cases, the soldier often showed a resurgence of the neurotic symptoms which prevented a return to the same situation which provoked the original reaction. Those who developed gastro-intestinal symptoms in the form of vomiting had the worst prognoses for eventual return to duty. The percentage of combat cases with severe reactions who returned to any form of duty in the European theater was disappointing. However, the early removal of the incapacitating symptoms made the problems of handling

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large numbers infinitely easier and obviated the possibility that the reactions might become fixed with time. The writers have felt that these factors, plus the patients' resistance to amytal hypnosis, warranted the use of electric shock, regardless of the eventual disposition.

What part did the primal fear of combat, or the psychological conflicts of the combat situation, play in the production of the reaction? A group of patients was received from the marshalling area just before D Day; and, in their delusions and hallucinations, they clearly indicated that this factor was predominant. A similar group was returned from France after little or no combat experience, or with minor wounds. In the lightly wounded, the mental symptoms usually appeared when the surgical condition cleared sufficiently to warrant consideration for further duty. Despite the fact that many patients were reassured by statements that they were to be returned to the Zone of the Interior, they were resistant to amytal hypnosis.

When the psychotic picture cleared with electric shock, a new group of symptoms, usually neurotic, developed with the prospect of a return to further duty. The writers were, therefore, forced to the conclusion that these patients had been unable to resolve the conflict between their urge to conform to the demands of the army, which represented their society, and their primal urge for self-preservation. However, there was a small number of patients in whom the factor of self-preservation was not the apparent precipitating cause. These men gave a history of marked feelings of well-being and pleasure, experienced during the active combat. They developed their psychotic-like behavior while resting in an area behind the lines. Several of these patients had been decorated for individual bravery in Africa, Sicily or France. It seemed probable that the loss of adequate outlets for aggressive tendencies precipitated the abnormal reactions.

If the cases reported in this paper were often related to the situation, should they be labelled with psychotic diagnoses? There was considerably less difficulty in the manic-depressive psychosis. This diagnosis was limited to those patients who gave an adequate history of the disease, and it was easier to get evidence that the

disease had been present long before army service. However, the diagnosis of the schizoid reaction was more difficult.

In 1911, Bleuler introduced the term "schizophrenia" to describe the functional mental disorders which were characterized by the "splitting of personality." In this group, he included the cases of dementia præcox described by Kraepelin, the paranoid conditions, hallucinoses, etc. Some modification of this point of view was made by Adolf Meyer and his school. The Meyerian school has considered schizophrenia to be a group of individual reaction types which had similarities. Meyer's group has discussed the various factors which might predispose to such a pattern—heredity, physical and mental defects—but has come to the conclusion that none of these produce the disease. Rather, they conclude that the individual responds to a situational or psychic conflict with a reaction pattern of a schizophrenic type. This is pathologic only when it exceeds the adjustment to the individual's particular local situation. When the patient with a predisposition to schizoid behavior is faced with a difficulty, either physical or psychic, a syndrome appears resembling one or another form of schizophrenia. Experiments with high altitude anoxemia have shown that normal individuals deprived of oxygen exhibit neurotic and psychotic pictures; and, on successive tests under the same conditions, the reaction has been constant for the individual. Some of the subjects tested under high altitude anoxemia have shown a schizophrenic pattern (McFarland, 1939).

One of the present writers (W. Goldfarb) investigated the schizoid features of acute alcoholics, particularly the paranoid dementia præcox reaction. Ordinarily, this disappeared in five to 10 days without any specific form of therapy; but when these patients were again subjected to a moderate trauma, such as insulin hypoglycemia or amytal hypnosis, a similar paranoid system again appeared. It is well known that schizophrenic attacks may be precipitated in association either with an apparent physical disease or with psychic trauma (Herman et al., 1940; Klasi et al., 1939).

The examiners in the army cases cited in the foregoing were extremely reluctant to make diagnoses of dementia præcox because of the obvious differences between these cases and those seen in civil practice. A psychosis generally indicates a malignant prog-

nosis which would disrupt the process of the patient's adjustment in civil life, and would involve unwarranted compensation aspects. The present writers are in agreement with Duval and Hoffman (1941) that these reactions have characteristics of both a psychosis and hysteria, and that there is no satisfactory nomenclature for these states. To clarify the status of these patients, and indicate the predominance of the situational factors, the writers could suggest that these conditions be diagnosed combat reactions or reactive regressions, manifested by symptoms of repression, conversion, regression, etc.

One of the most difficult problems encountered in the treatment of the combat case was what the writers have termed a disorder of attitude. This was often the sole difficulty; or it was one which would appear when the psychotic symptoms were alleviated. The form was variable and the following are verbatim examples typical of this disorder: "I have done my part, I want to go home. Let someone else finish it." . . . "I am not fit for combat duty and will not serve in a noncombat unit, therefore I should be sent home." . . . "If I can't serve with my old outfit, I can't do duty at all." . . . "I am just as sick as the other fellows going home, and why can't I be sent home as well?" . . . "I am sick of the ETO [European Theater of Operations], why don't you send me to the Pacific and I will fight there?" . . . "I have a great deal of trouble at home and I must go home to take care of the situation."

In many of these cases, the personality and background were immature in type; and often there was a history of a well-protected environment. In the patients who exhibited a neurotic background, the neurosis was never severe enough to warrant medical care. Many patients expressed concern over situational difficulties with their wives, over illness in the family, or over financial difficulties of various kinds. These patients were found to be very resistive to all forms of psychotherapy, and treatment has been unsatisfactory within the situation. Their reactions appear to resemble the tantrums and immature projections of the child. These patients express simple wishful fantasies without mature insight into the total situation and with a poor emotional adjustment.

In those cases which developed this disorder of attitude after considerable combat experience, the writers felt that the illness was

an acute one and amenable to therapy. The treatment prescribed was based on mental hygiene principles of child psychiatry in that an attempt was made to refrain from rewarding the patient by returning him to an overprotected environment (Zone of the Interior) if he would change his attitude. If a more mature insight could be obtained by therapeutic interviews, the patient was returned to duty through the usual channels. Failing this happy solution, the patient was sent to an army recovery center where the opportunity for gain through illness was at a minimum and where the antagonistic type of attitude disorder was discouraged by fair, strict uniform discipline. The reports from such recovery centers were that these patients rapidly achieved better adjustments as soon as the factor of gain through illness was entirely eliminated. The writers would recommend this method of treatment in selected cases, in particular with the aim of preventing the patient from becoming conditioned to gaining his ends in an immature fashion.

Summary

Case histories representative of the various types of neuropsychiatric reactions of combat personnel have been reviewed. Patients who were resistant to the prevalent forms of therapy, narcotherapy, hypnosis, modified insulin, etc., were treated with "shock" treatment. Approximately 90 per cent showed improvement.

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TRUE AND FALSE CONCEPTIONS OF PSYCHOANALYSIS

BY SANDOR S. FELDMAN, M. D.

There are many false and distorted conceptions of psychoanalysis. In general all sciences share this fate. The causes of this regrettable phenomenon are obvious. People in the majority are infantile and want easy and quick gratification. Thinking demands temporary frustration until the gratifying result is achieved. The infantilism of mankind resists this displeasure, however temporary. Therefore people in general deal with science in a superficial and loose manner. Only the "simple" concepts are adopted; the others which need work, time, and thinking, are distorted and reduced to superficialities. Psychoanalysis has a hard lot among the sciences. It is doubted whether it is a science at all, or "just" art, or, a combination of the two. The method of research in psychoanalysis is entirely different from that of the other acknowledged sciences; the testing of evidence takes place more on emotional than on intellectual lines; the terms are mostly borrowed from other sciences and it is hard for the so-called scientifically-trained mind to lend itself to conceptions which sometimes seem very subjective.[1] The human mind is confronted with reality in the form of problems no matter whether this reality means the outer world or the body. Experts who deal with problems of which a person is ignorant are respected; but, because one has access to his own mind, one feels himself to be an expert in psychology; and, therefore, if he dislikes a psychoanalytic statement he dares think himself right, and the statement, or the whole idea of the science in question, wrong.

Under such circumstances there is nothing else to do but just to go on one's own way in the hope that when the conceptions a science has offered are true and correct they will eventually be accepted and become a common possession of mankind in its struggle for existence.

Psychoanalysis: Science or Philosophy?

Science is systematized knowledge gathered through observation. Philosophy according to Nietzsche "traverses the whole

*Read before the Torch Club, Rochester, N. Y., June 20, 1945.

range of human values and estimations, it is able with a variety of eyes to look from the height to any distance in the domain of the logical, political, moral or artistic, to grasp the future with a creative hand."[2] Enthusiastic admirers of psychoanalysis, artists, especially writers, look upon psychoanalysis as a panacea for the sufferings of mankind. One can read about the "Freudian man" as a model human being. Through the help of psychoanalytic treatment patients expect to become supermen, and hope not only that it will draw out from them, but also that it will create in them, the highest abilities a human being might have. Many want to find in it a new religion, but "it is not a substitute for religion which an age longing for faith is trying to make of it."[3] Freud himself emphasizes that "psychoanalysis is not, like philosophy, a system starting out from a few sharply-defined fundamental concepts, seeking to grasp the whole universe with the help of these and, once it is completed, having no room for fresh discoveries or better understanding. On the contrary, it keeps close to the facts in its field of study, seeks to solve the immediate problems of observation, gropes its way forward by the help of experience, is always incomplete and always ready to correct or modify its theories. There is no incongruity (any more than in the case of physics or chemistry) if its initial concepts lack clarity and if its postulates are provisional. It leaves their more precise definition to the results of future work."

Thus psychoanalysis is not a philosophy, it is not a substitute for religion; but it is (as Freud designates it in his last-mentioned paper), "the science of the unconscious mind," it is "the name of a procedure for the investigation of mental processes," it is "the name of a method, based upon that investigation, for the treatment of neurotic disorders," it is "a collection of psychological information obtained along those lines and accumulated into a new scientific discipline," it is "an art of interpretation (on the basis that neurotic symptoms are substitutes for other mental acts which have been omitted) of associations." Psychoanalytic treatment does not intend and is not able to create a perfectly new individual; but on the other hand, it is able to free a person from his own shackles, bring him to grasp his own self, and make him become what he really is. Psychoanalytic treatment aims at bringing a

person approximately to a standard he could have achieved without help if pathogenic inner and outer factors had not interfered with his development.[5] The "ego" has to deal with all the demands of the outer and inner needs, and the ego of the neurotic is mainly taken up by his fight against his instinctual drives and by the intricate mental calisthenics he has to invent in order to cloak, to distort, to mask them, and to bring about a compromise between them and his conscious ego. According to Freud, the aim of psychoanalytic treatment is to achieve for the patient "the most far-reaching unification and strengthening of his ego, to enable him to save the mental energy which he is expending upon internal conflicts, to make the best of him that his inherited capacities will allow, and so to make him as efficient and as capable of enjoyment as possible."[6]

The Significance of Sexuality in Human Life and in the Etiology of the Neuroses.

To Freud, sexual instinct is identical with the life instinct; and it is made up of component instincts, the sources of which are the organs of the body, not only the genitals, but all important functional processes of the body. From all these bodily sources, stream stimuli to the mind—psychically represented by the ego—which demand that it take steps toward gratification. No other scientific assertion has met with such bitter resistance as has the so-called "libido-theory" of Freud. To determine the nature of the instinctual energies in the bodily processes is the task of chemistry; psychoanalysis deals with it only in so far as these energies represent stimuli to the mind and insofar as this phenomenon can be investigated by the psychoanalytic technic invented by Freud. Resistance to the assertions of the libido theory has been somewhat weakened by the latest discoveries of biochemistry, in so far as we know now much more about the basic life-processes of the cells of the body, but there is still a reluctance to accept the reflection of those processes on the mind.

If sexuality, including genital sexuality, is the indispensable motor of life, and even of the condition of health in general, then how is it possible that sexuality should be the cause of all the mental, emotional, troubles of life, as it is thought Freud claims?

This is not so. It is a false conception, and Freud never made such a statement. It is not sexuality that is the cause of the neuroses, but, rather, the conflicts with sexuality and the disturbances of sexual life. Freud explicitly states: "Neuroses in general are an expression of disturbances in sexual life, they are the consequences of BYGONE injuries to a biological function."[7] Furthermore, Freud never maintained that the sexual instinct is the only instinct playing an important rôle in mental occurrences. "On the contrary, psychoanalysis has from the very first distinguished the sexual instincts from others which it has provisionally termed 'ego instincts.' It has never dreamt of trying to explain 'everything,' and it has traced back even the neuroses not to sexuality alone, but to the conflict between the sexual impulses and the ego."[8]

Before going further toward understanding why and how conflicts between instinctual urges and the ego take place, which is the basic question of the etiology of the neuroses, one must dissipate another rude misconception of psychoanalysis.

To Avoid or to Cure Neuroses Should One Give Free Rein to Sexuality?

"Traumatic" injuries suffered during the delicate process of sexual development, cause conflicts which when solved irrationally prevent full sexual gratification later; and the individual feels frustrated. On the other hand, when such injuries have been more or less "satisfactorily settled" originally and a person can be considered emotionally balanced, outer real frustrations may revive dormant conflicts; and, in this way, a state of inner and outer frustration is created. In the latter case, the removal of the outer frustration usually cannot dissolve the conjured-up inner conflict. In both cases, the aim of psychoanalytic treatment is to solve the conflicts and render the individual healthy enough to strive for and achieve full gratification. This has been disastrously misinterpreted by the general public. The misconception, for which psychoanalytic science cannot be held responsible, is that in order to avoid becoming neurotic one should indiscriminately indulge in sexual lust or lewdness, and that the remedy for an already present neurosis is to give free rein to sexuality.

This is a misconception. The truth is that the neurosis makes it impossible for a person to achieve proper sexual relations. The truth is that the neurosis is responsible for the inability of a person to attain full satisfaction in his love-life. It is not the actual frustration that causes the neurosis; on the contrary, the neurosis causes the frustration. Neurosis is an inner failure to deal with the difficulties of life. A normal person is able to endure unavoidable frustrations, a healthy person will do his best to remove the obstacles to gratification. The neurotic fails, even if the best opportunity for normal gratification is given to him; or he is unable to create suitable conditions for his gratification.

"To believe," writes Freud in the same paper discussed in the foregoing,[7] "that psychoanalysis seeks a cure for neurotic disorders by giving free rein to sexuality is a serious misunderstanding which can only be justified by ignorance. On the contrary, the bringing to consciousness of repressed sexual desires in analysis, makes it possible to obtain a mastery over them which the previous repressions had been unable to achieve. It can be more truly said that analysis liberates the neurotic from the chains of his sexuality."

The Truth About the Etiology of the Neuroses.

In order to survive, to remain more or less emotionally balanced, a person, among other things, has to meet his instinctual needs. But there are three kinds of grave difficulties affecting this, which are specific to the human species. All three can be considered the basic causes of the neuroses. These difficulties are of a biological, phylogenetic, and psychological nature.[9]

(a) *Biological.* The human infant—unlike other beings in the animal kingdom—is for long years dependent on the care of his mother or her surrogates. Any kind of object, no matter whether living or not, is felt and accepted as friendly only when it supports the gratification of his needs. If the writer may be permitted to coin a word, the infant "motherizes" everything in the outer world, and when the "mother" is not easily available, he creates this mother by creating institutions which replace her (Róheim). In one form or another, he must have an object to cling to, to grasp (Hermann). Otherwise, he feels insecure, unprotected, and

afraid. This dependence creates in the human being an insatiable craving for love, and either prevents or makes difficult the achievement of independent partnership with the love object. At any sign of outer danger, the human being is inclined to seek refuge with his mother, to attach himself to her, as a consequence of which, in the period of sexual maturity, he is brought into the socially objectionable incestuous relationship. To mention another example, this biological fact might leave its stamp on a person's adult sexual life, especially in marriage, making it difficult for husband and wife to feel like equal, independent partners, to be self-reliant, and to love each other like two mature persons. As time goes on, this outcome of early relationship to the mother might extinguish the sexual attraction in marriage, the relationship tending to become desexualized.

(b) *Phylogenetic.* The psychosexual development of the human being takes place in a dichronous way: i. e., after the development to a stage is completed, at the age of five, a latency period follows until puberty, when development starts again but with a tremendous burden, the burden of the instinctual forces of the infantile sexuality, which are treated by the ego like dangers. Infantile memories, though more or less repressed, exert great attraction upon sexuality at puberty and make the latter as dangerous to the ego as infantile sexuality once was. The actual objects become confounded with the infantile images, causing anxiety, confusion, and —neurosis.

(c) *Psychological.* This consists of the peculiar ability of the human mental apparatus to treat inner instinctual dangers just as it deals with outer dangers; that is, it withdraws from them by means of inhibitions, by means of symptoms, in short by the restriction of the ego. Only a human being is able to do what, for example, one of the writer's patients accomplished. He was a hunchback and, when the writer first saw him, was about 35 years of age. Once while walking on the street in his home town, he noticed two dogs fighting and snarling at each other; and this not unusual sight caused him great anxiety. From that time on, he was afraid to walk on the streets for fear that a dog might attack and bite him, and that the dog might be a rabid one and infect him, causing his death. In his analysis, it turned out that he hated every able-

bodied man. He never had experienced a sex relation, and he had resolved that he could accept only a very attractive, beautiful girl as a sexual partner. An able-bodied man does not need to make such conditions. But this patient did, in order to prove himself as valuable a male as any able-bodied man. Because he failed in this respect, he gradually came to hate men. Being otherwise a kind and decent human being, he did not like this—and he identified himself with a rabid dog. He was afraid of this rabid dog within him. Furthermore it hurt his self-respect. How did he get rid of this dangerous impulse and maintain his self-respect? It was by projecting the whole danger from the inside on to the outside, by creating a symptom, by the restriction of the freedom of the ego. The ability of humanity to create and to use symbols—in this case aggressive impulses symbolized by the rabid dog—contributes to the ease with which man is able to engineer an intricate neurosis.

Does Psychoanalysis Destroy Everything That Is Beautiful and Lofty by Tracing It Back to Primitive Biological Forces?

Psychoanalysis claims that the fount of human life is the human body and its processes. The spiritual accomplishments of mankind, his morals, ideals, his ethical and social senses, were brought forth by inhibiting (it is a reasonable inhibition) his instinctual aims, by sublimating the instinctual goal, the physical gratification. A narcissistic resistance objects to this Freudian assumption; and because this resistance has to be denied—for the same narcissistic reasons—the objection is rationalized by the accusation that psychoanalysis undermines religion, authority, and morals, and furthermore that it reduces our gratification in art, research, love, etc. This is a false conception if not sheer nonsense. First of all, as Freud puts it, "psychoanalysis like every science, is entirely non-tendentious and has only a single aim—to arrive at a consistent view of one portion of reality."[7] Second, the whole objection is a *petitio principii* because the objection is taken fallaciously by the objector as granted without his ascertaining whether it is true. The facts prove just the opposite, at least they do not verify the objection. Psychoanalysts themselves are deeply devoted to life, art, ethics, morals and ideals.

The writer has never observed in the analyses of patients—unless they were treated by self-styled analysts without proper training and recognition by analytical bodies—that the dignity of the so-called high human values has been reduced by the analytical process. On the contrary, having at his disposal all instinctual forces, the patient becomes able to distinguish between rational and irrational inhibitions; he becomes able to divert the surplus and the antisocial part of his instinctual drives to other channels; he becomes master of himself instead of being enslaved. Other things being equal, the physiologist, when eating, is not disturbed by his knowledge of the elementary structure of the meat or other foodstuffs. Neither is the romance of a healthy obstetrician or gynecologist disturbed by the knowledge he possesses. The student of anatomy—provided he is not neurotic—does not, when kissing a girl, think of certain muscles and their innervations, etc. Science, the knowledge of facts, not only deepens our thinking but also elevates our desire and ability to gain a comprehensive view of the universe, and the place and the rôle of humanity in it.

Is It True That According to Psychoanalysis Man Is Intrinsically Wicked?

From many quarters, poisoned arrows have been aimed at psychoanalysis, accusing it of not only bringing out the iniquity in man, but also of teaching that man is fundamentally vicious and that the good is only a thin veneer upon his surface. This is both a stupid and completely false accusation, a foundationless misconception of psychoanalysis.

The truth is that, according to psychoanalytic research, man has two kinds of drives. One aims at the preservation of life, and the other at the abolition of tension caused by bodily urges. The abolition of this tension is followed by a feeling of gratifying pleasure. It is true that in analysis, in addition to the so-called evil which is brought to the surface, the deep intrinsic social feelings and the recognition in all of us of a true conscience which is not venal and mercenary, are also brought out. The truth is that according to the libido theory of Freud—which is a theoretical condensation of the findings on the psychosexual development of the human being—our psychosexual development can be generally divided into two

phases: the pregenital and the genital. The pregenital is a polymorphous-perverse phase, the genital sensations having little importance, and the main social characteristic of the individual at this stage of development is that he is not kind and tender at all and does not consider the desires, the gratification, nor indeed the physical integrity, of the object (nor even of the subject himself). In the course of development the different pregenital erogeous zones become fused with the genital urges, thus bringing the pregenital ones into the service of the genital gratification.

The main characteristic of the latter phase is the regard for the object, the consideration for the gratification of the object, kindness, tenderness, and the preservation of the physical integrity of the love-object. Any kind of obstacle in the way of the instinct of self-preservation, or, in the way of genital gratification, (usually irrational inhibitions work this way) calls forth aggression, hate, envy, jealousy, i. e., a regression from the genital to the pregenital level of psychosexual development. On the latter level, the sadistic and masochistic tendencies occupy a special and important rôle. The truth is that man possesses an inherent tendency to progress toward the higher level of social and sexual interpersonal relationship, and that in this process he uses all the "evil" in him fo work for the "good."

By What Means Is Help Achieved in Psychoanalytic Treatment?

Analysts are often asked by interested people: "If the cause of a symptom is brought into consciousness, will it then disappear?" In cases in which there is no specific neurotic background, and a recent blow—trauma—has been followed by disturbances, as in rare special cases of traumatic neurosis, it is possible (but not certain) that the symptoms may be removed in a cathartic way, by bringing into consciousness the irritating event, the event which was prevented from becoming conscious because the sudden impact did not permit the patient to be prepared for it and consciously to digest it. But in most cases the therapeutic process is not so simple. One must bear in mind that neurosis is a defense-product against instinctual drives stimulating a person in certain specific situations of his life. The neurosis as a defense is not created in a moment even if it seems so. It is preceded by a series

of "prodromal traumatic cycles," the bulk of which have to be unearthed before the patient can conceive the basic and general sense of his neurosis.[10]

Because the neurosis originally was a defense and remains so, no matter how much suffering is caused by it, the patient will offer resistance against the analytic aim, which is to bring to consciousness the primary stimuli. This resistance is unconscious, and through it the patient makes desperate efforts against the analytic process. It is this resistance with which the analytic process has to deal. It is attacked by the analyst with all the means at his disposal, through the hundreds of different phenomena offered by the patient. It is the function of the analyst to discover resistances. Only in this way is it possible to get to the psychic conflict which underlies the symptoms. The change in the patient in being able to give up resistances barring the way to consciousness, is mainly responsible for the therapeutic results, and not only the discovery of the basic conflict which usually is a banal one—banal because it is so similar in every person.

There are other factors which contribute to the change. Hitherto, conflicts were never expressed in words. In analysis, discharge of emotions takes place by expressing them through words. Repressed emotions, unless they are expressed in words, adhere to the person. Thinking about his troubles is in the neurotic very intensive, but still inefficacious. In the analytic process, deep thinking is achieved. This strengthens the reality faculties of the person; he becomes more mature; and this is another factor which helps him to abandon the irrational self-torture of his symptoms. (Hermann.)

Another common misconception is very often expressed in the remark: "I know what caused my symptom and it is still there." A woman close to the sixties, whose life was substantially paralyzed by her fear and horror of cockroaches, thought that she knew how her fear originated. At the age of eight, she spent a vacation at the home of her aunt. One night in the children's room she and two other children were entertaining themselves and having a good time, while waiting for the return of the uncle and aunt. The house lights were out. The couple came home, turned on the light, and our patient heard the aunt cry out in horror: "Cockroaches!" At

this moment she felt a great horror, and from this time on, developed a phobia. Thereafter, her main occupation was to avoid contact, even remotely, with these vermin. Cleaning all day long, she could not sleep for fear that during sleep her cover might slide down and she would inadvertently bring a cockroach into her bed, etc. This patient asserted that she knew the cause of her phobia. Really she did not know anything, by knowing what she did know. She did not know why the fearful comment of her aunt had such a lasting effect on her mind. She had to learn in her analysis what had been happening for years before this, she had to discover the instinctual drive working in her dormantly, which came up in symbolic form. There is a great difference between knowledge and knowledge.

The aforementioned considerations take care of another misconception, namely, that analysis helps by suggestion, by talking something into the mind or out of the mind of a patient. The writer again quotes Freud, from the article often mentioned in this paper: "Psychoanalysis differs from all methods making use of suggestion, persuasion, etc., in that it does not seek to suppress by means of authority, any mental phenomenon that may occur in the patient. It endeavors to trace the causation of the phenomenon and to remove it by bringing about a permanent modification in the conditions that led to it."

Psychoanalysis and Art.

In his encyclopedic paper, Freud avers that psychoanalysis is a depth-psychology, "a psychology of those processes in mental life which are withdrawn from consciousness," and, as such a psychology, is "capable of being applied to the mental sciences (religious and cultural history, mythology, literature, psychiatry, education."

At the advent of the psychoanalytic movement, the analysts in their loneliness caused by the indifference, and by the sometimes bitter opposition and ridicule of the professional scientists, appreciated the supporting interest of the many artists who joined the movement. Psychoanalysis considered Dostoevski, Shakespeare, Schopenhauer and many others as the forerunners of the psychoanalytic-depth-psychology. The analysts felt intuitively that unconscious motivations give subject matter to the artist, who by his

formative talent is able to put them into a form which circumvents resistance, thus leading the way to gratification.

In many thrilling papers, first Freud and Rank, later others, studied the productions of many artists and discovered in them the deep and common fantasies with which mankind has struggled since time immemorial. But "Freud himself felt vividly that psychoanalysis cannot, and never did, attempt to explain the essence of art or any creative activity. But he discovered the connection between the erogenous zones and the manifold expressions of creative spirit."[11]

It is a foundationless accusation against psychoanalysis that this psychology finds "the root and source of power and genius in neurosis."[12] Perhaps some analysts writing on this subject are not quite fortunate in their mode of expression, thus misleading the reader into the belief that according to psychoanalysis a neurosis makes a person an artist. This is a monstrous idea, and no analyst has ever intended even to suggest it. The truth is that the artist is extremely sensitive to everything deep in man no matter whether potential or actual. The artist has the genius and talent to conjure up in a constructive form the forces operating in the innermost depths of his being. This is art. Through his deep intuitive understanding of symbols, the artist is able to take us far back to the beginning of our cultural existence. He makes us feel how we began to express our instincts in form, and thus makes us able to encompass the meaning of our existence.

As far as the instincts are concerned, the artist is not different from other people; but, being an artist, he is endowed with the talent to feel them and to express them. He may be neurotic like anyone else, but his neurosis is an individual production, unlike his art, which is his biological inheritance and a superstructure upon his individual life. As an artist, he is the carrier of a productive power which is beyond his individuality, and, therefore, his individual subject-motives may determine his subject, but not his genius. The two are not related. Neurosis does not make an artist, and art does not prevent a neurosis.

This leads us to a second misconception prevalent even among artists, that psychoanalytic procedure might ruin the talent of the artist. This is sheer nonsense. On the contrary, it helps him, be-

cause, as Hermann Hesse writes so convincingly, the treatment strengthens the artist in his feeling that his fantasies, his fictions, are a forceful motor of mental life. It encourages him to be truthful to himself and he gains easier access to his unconscious.[13]

Scientific and Unscientific Dream Interpretation.

The Freudian interpretation of dreams is one of the touchstones of psychoanalysis. It proves Freud's fundamental assumption that "the psychic apparatus is ruled by the tendency either to discharge incoming stimuli completely or to reduce them to the lowest possible level. One of the basic functions of the psychic apparatus is thus the abolition of stimuli."[14] This tendency rules in the psychic apparatus even during the night, and serves the purpose of securing sleep by turning outer and inner stimuli into hallucinatory actions. "The dream is the guardian of sleep;" at least it does its best, though it fails in the anxiety dreams which awaken the sleeper when the stimulus is too strong.

As a consequence of superficial reading, reluctance to admit ignorance or to sacrifice time and work for deeper understanding, there is the widespread fallacy that the symbolic language of the dream can be simply translated into everyday language. The truth is that, excepting some typical dreams, it can scarcely be interpreted without the associations of the dreamer. In the course of treatment, the analyst who has learned a great deal about the dreamer, may be in an easier position, but even he, more often than not, is highly dependent upon the associations. Even the skilled dream-interpreter-analyst is most secure when he is using his skill and intuition only after having collected some association material. With certain exceptions, one should completely disregard the manifest dream content of the dream, the rough text as it is remembered by the dreamer. The dream should be treated exactly as another symptom, that is, its latent, repressed meaning, the latent dream thought, has to be discovered by the dream interpretation. It is not true that the dream is nothing else but the careless elaboration of some event from the previous day. It is true that the "residues of the day" serve as an occasion for the dream, but the instigator of the dream is always a repressed motif.

One of the popular unscientific methods of dream interpretation is the symbolic dream interpretation. The manifest dream con-

tent is replaced by another one which is either attractive or sensible, and which, therefore, can be accepted by the dreamer no matter whether it is correct or not. It rarely happens that this method of interpretation is correct, as in the interpretation of the dream of the biblical Joseph by his family. In Genesis, Chapter XXXVII, we can read the following: "And when his brethren saw that their father loved him (Joseph) more than all his brethren, they hated him, and could not speak peaceably unto him. And Joseph dreamed a dream, and he told it to his brethren, and they hated him yet the more. And he said unto them, 'Hear, I pray you, this dream which I have dreamed: for behold, we were binding sheaves in the field, and lo, my sheaf arose, and also stood upright, and behold, your sheaves stood round about, and made obeisance to my sheaf.' And his brethren said to him 'Shalt thou indeed reign over us?, or shalt thou indeed have domination over us? And they hated him yet the more for his dream, and for his words. And he dreamed yet another dream, and told it to his brethren and said, 'Behold, I have dreamed a dream more, and behold, the sun and the moon and the eleven stars (Joseph had eleven brothers) made obeisance to me.' And he told it to his father, and to his brethren, and his father rebuked him and said unto him, 'What is this dream that thou hast dreamed? Shall I and thy mother and thy brethren indeed come to bow down ourselves to thee to the earth?' " The family immediately understood the dreams of Joseph. They lived with him, knew him and his great ambition. The sun is an ancient symbol of the father, and the moon that of the mother, the stars were then easily interpreted as the 11 brothers. Joseph apparently underestimated the interpreting skill of the family, otherwise he, who himself later became the great and official dream interpreter of the Pharaoh, would not have told them his dreams. He did it to his later sorrow. The Talmud produces another example of such symbolic dream interpretation: "A man came to Rabbi Jismael ben Rabbi Rose and told him: 'I saw in my dream that my eye kissed the other eye.' He answered him: 'Your soul should leave you. You have slept with your sister!' "[14] The main scientific objection to this dream interpretation is that what could have been only a wish, and then only a repressed one, is considered factual. Another objection is that the dreamer is made responsible for the dream.

A perfectly worthless popular method of dream interpretation is the cypher method. "It treats the dream as a kind of secret code in which every sign is translated into another sign of known meaning according to an established key." (Freud: The Interpretation of Dreams.) For example, "He who in his dream sleeps with his sister, can expect to become wise because it is said (in the Proverbia); 'Speak to wisdom: you are my sister;' " or: "He who in his dream sleeps with a married woman, can be certain of a life hereafter, but only if he does not know the woman, and if he did not think of her before going to bed." And the last one of this kind: "In my dream I swallowed a star" (said a man to the interpreter). He answered him: "Go to hell, you have killed a Jew because the Bible says: 'A star will sprout out of Jacob.' "[16]

The scientific dream interpretation is somewhat different. It does not predict, does not claim that the dream has a creative character, and considers a dream to be a distorted presentation of a repressed motif. For example, here is the interpretation of a comparatively simple dream of a woman: "I combed my hair and to my great despair a bunch of hair came out through the combing." What is the repressed motive of this dream, what is the latent dream thought? The writer asked the dreamer what the fallen hair looked like, and she said that it was not hers, it looked like the hair of her daughter-in-law. The dreamer is an old woman who once was a beauty and suffers a great deal at any sign of aging. Certainly one agrees that she cannot wish to lose her hair. The dreamer's marriage has always been an unhappy one, and, as it happens so often in such cases, she has lavished all her affection on her only son. He was always kind and affectionate to her, and still is. But since he is married, and living with his wife in his mother's home, things have changed somewhat. On the night previous to the dream, the dreamer was sitting in her living room with her daughter-in-law, waiting for the son. He arrived, dashed immediately to his wife, who, by the way, has beautiful hair, and stroked her head. He merely gave his mother a kind greeting. Now one can recognize the latent dream thought: "If my daughter-in-law lost her hair, my son would not love her so much. I am ashamed to have such a desire, for I love her, and as a mother I am happy that they love each other so much and that she has such beautiful hair." The dreamer is unhappy because of her conflict.

What Kind of Scientific and Therapeutic Concept in Psychology Should Be Considered Psychoanalysis?

Freudian psychology is usually confounded, especially among laymen, with other schools of psychology, because the persons who represent the other schools once worked on the psychoanalytic campus under the leadership of Freud, or were his pupils personally or indirectly. Some of these wish to be distinguished from Freudian psychoanalysis, and some do not. It is of common interest to know exactly what each school professes. At the present time the schools which claim that they can see further, deeper, and better, than Freud, are the following: the school of Jung (racial psychology), of Adler (individual psychology), of Rank (individualistic—or will-psychology), of Horney and Fromm (advanced psychoanalysis or culturalism), of Reich (sex-economy), of Reik (neo-psychoanalysis), and of Alexander (neo-Freudianism). With the exception of Reik's and Reich's schools, they all have one common characteristic in that they all discard the fundamental conceptions of Freud. Psychoanalysis is the brainchild of Freud; he worked a long life-time to develop it, he shed blood and sweat to protect it as a science against those who, for whatever reasons, wanted to offer an acceptable working philosophy or psychology to suffering mankind. In his encyclopedic paper Freud writes: "the corner-stones of Psychoanalytical Theory" are "the assumption that there are unconscious mental processes, the recognition of the theory of resistance and repression, the appreciation of the importance of sexuality and of the Oedipus complex—these constitute the principal subject-matter of psychoanalysis and the foundations of its theory. No one who cannot accept them all should count himself a psychoanalyst."

Most of the other schools do not live up to these conditions. The difference between them and Freudian psychoanalysis, and the differences among themselves, are substantial ones.

Freud maintains that we are all fundamentally alike, that as far as our unconscious is concerned (and only this counts), there is no difference at all in mankind. Jung, on the other hand, believes that we have a collective and an individual unconscious which clash, causing mental disturbances. According to him, we are only racially alike—otherwise different—and, therefore, every race has

and needs a different psychology. Adler deplores the difference between man and man, but he is confident that we all could be alike in a social sense. Trouble arises when a person fights against his social feelings and becomes an individual just for himself. Rank rejects Freud's determination. He is vitalistic. To Rank, neurosis is a conflict between the rational and the irrational in man, and follows upon an excessive control over his own nature by the individual will, instead of being the result of social inhibitions, or repression of impulses.[17]

Horney and Fromm postulate that at the bottom of a neurosis in our time is always the anxiety which springs from hostile impulses of various kinds arising from the nature of our culture. This culture is competitive and creates in us "the feeling of being small, helpless, insignificant, deserted, endangered, in a world that is to abuse, attack, humiliate, betray, envy." The school of Reich adheres to the original and partly abandoned conception of Freud, that the anxiety (which is the basis of neurosis) is repressed, and therefore ungratified, sexual libido. The libido-stasis causes not only conflicts and neurosis but also creates the basis for different organic diseases. Reich ascribes to sexuality a greater importance than does Freud, and finds that perfect genital orgasm is the basis of psychic and organic health. He is the "stormy petrel" of psychoanalysis, and his merits are unquestionably great.

Reik, the "neo-psychoanalyst," to whom we are indebted not only for many profound and fundamental contributions especially in applied psychoanalysis, but also in many other respects, considers Freud's libido theory "a magnificant mistake." He remains deeply devoted to Freud, but thinks many changes are imperative in the psychoanalytic building in order to adapt it to the changes which have taken place in the sciences in the last two decades. Alexander, the neo-Freudian, finds also that the libido theory of Freud is untenable, and he is seeking other dynamic forces which operate in the mind of man. Wittels writes of Alexander: "We see Freud's 'Three Contributions,' the greatest theory of sex since Plato, thrown in the ashcan by one of his most gifted, most ambitious, and, in the end, most unfortunate, disciples."

The difference in views reflects itself in different therapeutic approaches. We have spoken about the therapeutic aims of the

Freudian school. Jung aims to integrate the individual's personal wishes with the assumed aims of his particular race, and thus to achieve a unification of the individual with the group in which he can play an essential part. Adler advocates the development of a social feeling in order to become a "*mitmentsch*," i. e., one who wants to be no more than the other fellow. Because, according to Rank, the will of an individual means his creative expression which distinguishes him from others, psychotherapy must be based on an individualistic psychology, its aim being to adjust the person to himself, so that he can do his best with and in his environment.[17] Horney's therapy aims at showing the patient how our present culture drove him into anxiety, into different sexual and interpersonal conflicts, and to help him to a new adjustment. It implies as a prevention of neuroses the change of our economic and social structure. Reich tries through the analysis of the character to remove the defense-armory which prevents the perfect orgastic gratification. Reik's technic is fundamentally the original one, but he thinks that through the revision of certain Freudian concepts one works on more secure ground. Alexander would like to offer the individual a more stable culture to facilitate the task of finding a balance between tradition and changing culture.

In the writer's opinion, the segregation of Reik from the official psychoanalytic movement is a superfluous one, and the writer hopes that we shall see him back soon. Reich's separate standing is rather due to his enthusiasm in extending the result of his psychoanalytic investigations into the field of politics.

It is an absolutely false accusation that the Freudians treat new ideas with hierarchical intolerance. As long as we, who wish to call ourselves psychoanalysts in a Freudian sense, find no basic reason for abandoning the Freudian "cornerstones" of psychoanalysis, we cherish any new idea which improves and deepens our knowledge and technic of treatment. In lectures, in discussions, in the official analytic journals, the widest freedom is given to each analyst to expound his views provided he remains within the building of psychoanalysis. The moment we find that the cornerstones of Freudian psychoanalysis are shamstones, we will abandon it and put it as a relic in a scientific museum. Everyday experience with patients forces us to remain on the original psychoanalytical

basis. We who are "dyed in the wool" Freudians are compelled to be so by the analysis of our patients. Therefore, we have to consider the departure of a small number of the pupils of Freud either as a desire to give suffering mankind a wholesale new psychologic-religious panacea, or as the return of the once abandoned resistance against the recognition of the forces in the unconscious. As Freud writes at the end of his "History of the Psychoanalytic Movement:" "Men are strong so long as they represent a strong idea; they become powerless when they oppose it. Psychoanalysis will be able to bear this loss and will gain new adherents for those lost. I can only conclude with the wish that fate may grant an easy ascension to those whose sojourn in the underworld of psychoanalysis has become uncomfortable. May it be vouchsafed to the others to bring to a happy conclusion their work in the depths."

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THE TREATMENT OF PSYCHOSES WITH METHYL GUANIDINE SULFATE

A Clinical Report of 12 *Cases*

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Methyl guanidine sulfate was reported by Madden and Kaplan[1] to give results similar to those produced by convulsive therapy and insulin in the treatment of schizophrenia and depressions. The treatment was reported to be more economical, less dangerous and less unpleasant than convulsive therapy. Since, in addition to these advantages, it required a smaller personnel, it appeared ideally adapted to the requirements of a busy hospital where a large proportion of patients seemed to be in need of "shock" treatments. The patients to whom this treatment was administered were enlisted personnel or veterans of the United States Navy or Marine Corps. All were under treatment for psychoses diagnosed as schizophrenic or depressive in nature; most of the subjects were suffering from acute episodes for which electric convulsive therapy had been considered.

Methyl guanidine sulfate was given, as suggested by Madden and Kaplan,[1] five days a week for four weeks. Pulse and blood pressure readings were taken immediately before and after each treatment. Individual differences in tolerance made a consistent dosage impossible; following the initial dose of 4 cc. of a 25 per cent solution, the amount was increased daily until the maximum tolerated dose was reached. No patient, however, received more than 8 cc. at one time.

The clinical responses observed, as well as the final results, were similar to those reported by Feinstein.[2] The pulse rate tended to fall, although in the patients with the least apprehension before treatment, little change was noted. There was elevation of blood pressure in varying degree. The greatest change was from 140/80 to 218/115 in a 180-pound individual after injection of 950 milligrams of the substance. Flushing and dyspnea were consistently seen; marked apprehension, discomfort and tingling were usually reported.

RESULTS OF METHYL GUANIDINE SULFATE TREATMENT

Patient	Age	Service, months before illness	Chief characteristics of psychosis	Duration of psychosis before methyl guanidine sulfate (months)	Number of treatments	Result of methyl guanidine sulfate treatment	Course during six months following conclusion of methyl guanidine treatment
A	24	27	Silly, deteriorated, irrelevant	5	20	no change	Continued deterioration
B	22	12	Agitated, paranoid, depressed*	4	10	see note*	Discharged improved one month later
C	21	2	Passive, apathetic, somatic complaints	20	20	no change	Improvement after electric convulsive therapy, but still institutionalized
D	23	26	Seclusive, hallucinating, silly	46	20	no change	No change after electric convulsive therapy
E	22	38	Perplexed, retarded, delusional†	7	20	no change	Continues chronically ill
F	35	3	Combative, bizarre, hallucinating	6	20	no change	Slow improvement after electric convulsive therapy; discharged from hospital
G	25	20	Depressed, catatonic, retarded	6	20	no change	Temporary improvement after electric convulsive therapy, followed by relapse
H	27	10	Extremely paranoid, depressed **	3	3	no change	Discharged improved after electric conculsive therapy
J	23	18	Hallucinating, depressed, agitated	3	20	no change	Discharged improved after electric conculsive therapy
K	19	8	Silly, paranoid; later catatonic	3	20	no change	Began spontaneous remission one month after methyl guanidine sulfate
L	29	25	Persecutory delusions; depressed	3	20	no change	Discharged recovered after electric convulsive therapy
M	28	14	Depressed; olfactory hallucinations	5	20	no change	No longer depressed after electric convulsive therapy; remains chronically ill

*This patient had had electric convulsive therapy. His course oscillated between an agitated, paranoid depression and relative remission. After one week of methyl guanidine sulfate treatment, he improved rapidly, coincident with the first visit of his wife. Treatments were discontinued at his insistence after two weeks.

†No response to previous electric convulsive therapy.

**This patient, a large and muscular individual, aggressively refused further treatment.

Discussion

The results are recorded in the table. No changes were observed in the conditions of 10 patients who completed the full course. The patient who did improve coincident with incomplete treatment had previously shown temporary changes after electric convulsive therapy.

Of the eight patients who subsequently received electric convulsive therapy, one appeared fully recovered; three were well enough to be discharged to their homes; three were slightly or temporarily improved, and one, whose illness was of almost four years duration, showed no change.

Compared with electric convulsive therapy, the patients in this series seemed more uncomfortable during, and more antagonistic toward, methyl guanidine sulfate.

Conclusion

In a series of 12 service men whose psychoses demonstrated schizophrenic or depressive characteristics, better results were obtained with electric convulsive therapy than with methyl guanidine sulfate.

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ARCHETYPE POSTURES

Clinical Impressions

BY H. M. QUACKENBOS, M. D., L. R. C. P., M. R. C. S.

The adult female without mental disorder, in the circumstances prior to a clinical abdominal or gynecological examination—a hetero-erotic situation attended by essential supine passiveness plus exhibition—will normally react by a series of four upper-limb, archetype postures*

These several situational postural responses may be attributed in some instances to redintegration. They are, however considered here in terms of gestures expressing levels of maturity, and are ascribed to inherent recessive traits, a heritage-complex of archaism. The correlation of frequency in the adaptation of this behavior pattern to the situation is predictable in the majority of mentally healthy women and also in the female patient in the state of recovery from a psychosis. This general adult female correlation—reported here on the basis of clinical observation only—is not found consistently in men,† or children or in the apraxic female.

Let the patient be informed that she is to be prepared for the examination. There is a huge variety of positions in which supine women may place their arms; but the clinician is generally correct in the surmise that the relaxed patient on the couch will display the following procedure: (1) The right hand palm will be in contact with the nape of the neck, the fingers extended, touching the edge of the left ear. One has the impression that left-handed white women and negroid females tend to reverse this posture. If asked why she assumes this position, the normal woman will readily reply that she is embarrassed, does not know what to do with the

*The term "archetype posture" is restricted here to an unconscious response pattern associated with erotogenic zones. The writer thinks that subcortical, automatic behavior must be accompanied by dilated pupils, and its character is not similarly restricted.

†The first of the archetype responses which will be discussed is occasionally seen in the "neat and clean" type of man as a situational posture under circumstances similar to the abdominal examination of women. One's impressions are that such male patients as a class show neurotic traits, but whether such trends imply latent homosexual tendencies is a question outside the scope of the writer's knowledge.

hands and that the posture is a natural one. That is a wholesome realistic ontogenetic answer, but not the phylogenetic reason, which is probably as old as woman herself. When requested to place the arms elsewhere, the woman patient may or may not assume the posture listed here as number 2.

(2) Both fists are placed with the thumbs extended forward in contact with the crests of the ilia, the patient perhaps mentioning that the position is comfortable. This posture is of less antiquity than the first and may be expressed only by a gesture or omitted altogether for the next movement.

(3) The mammae are covered with the palms, before interlacing the fingers or moving the hands down to the edge of the chest. When further requested to place the arms elsewhere, the woman typically assumes posture 4.

(4) The extended arms, hands open, are placed nearly in contact with the outer thighs.

Conversely to adult behavior, a child in a similar circumstance of semi-nudity will usually place the arms as described in position 4, while the adolescent girl generally assumes posture 3. The hands on hips posture is not routinely seen as a subjective response reaction in youth.

As compared to the mentally normal patient, the psychoneurotic adult woman and the psychopath tend to place the restless hand in contact with the vault of the skull or to grasp anything in that region. The senile, the defective and the simple dementia præcox patient are more likely to assume the child-like posture. As to be expected, the catatonic patient places the arms in semi-flexion on the chest, while the hebephrenic rubs the eyes, like a child awakening from slumber, and, while indifferent to posture, usually assumes the palms on the mammae position.

The simple dementia præcox patient appears not uncommonly to have been the victim of the aggressive male with psychopathic trends; and the posture taken by the patient is of passing interest should psychopathic classification be considered. The gynecological findings in respect to the vaginal vestibule or introitus seem to have some relationship to functional psychosis, as for example the schizoid chastity of the elderly simple dementia præcox patient

who is certifiable by reason of a superimposed syndrome of organic reaction type. The catatonic patient presents an inflamed, vestibule with passive resistance and protest. In the pelvic examination of the hebephrenic type, one might well wonder whether there are two forms of the hebephrenic syndrome—as the unmoral and the virtuous—but it seems more likely that when chastity is found in the "hebephrenic" it is due to early commitment and custodial care, at a time when the mental illness is primarily a phase of catatonic excitement, which rapidly regresses to the chronic type of hebephrenic dementia præcox.

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SCHIZOPHRENIC-LIKE REACTIONS IN CHILDREN

(*Second Series*)

BY LEON N. GOLDENSOHN, M. D., ED R. CLARDY, M. D,.
AND KATE N. LEVINE, M. A.

In a previous publication, the authors presented a preliminary report on schizophrenic-like reactions in seven children (PSYCHIATRIC QUARTERLY, January, 1941). The present contribution of three entirely new cases is a continuation and development of that work, utilizing similar investigative procedures. The approach to the problem has been varied in only a few details. The plan of the psychological studies has been altered by abandoning some of the performance tests which proved unproductive in the previous study. More extensive Rorschach investigation has been undertaken, utilizing the graphic Rorschach procedure. Greater emphasis on the case history and an attempt at delineating the psychic structure are two additional points of departure from the first study. The writers have continued to utilize pneumoencephalography, electroencephalography, and general psychological tests.

CASE STUDIES

Case 1, *D. M.*

D. M., an 11-year-old white boy, was admitted to the children's group on September 3, 1941. The child was referred for treatment because of inattention, silliness, tantrums, and inability to adapt at home or in school.

He was born August 9, 1930, in Troy. The delivery was instrumental but not abnormal; both child and mother were in good physical condition; and the labor was not prolonged. D. M. was bottle-fed from birth, gained weight normally and in the first year tripled his birth weight of seven pounds. Teething and walking developed normally. Other psychomotor development was within normal limits except for talking, which was delayed until after the second year. Even at that time, he tended to utter isolated words which were comprehensive but rarely seemed appropriate.

Illnesses previous to his admission included measles at six and a tendency to asthmatic attacks at the age of five.

The father believed that the child was "normal" until the age of three; the mother tended to believe that the illness dated from birth. The parents were extremely poorly adjusted persons. The mother appeared disheveled, her hair unkempt, clothes nondescript. She answered all questions relevantly, but with a suspicious air; she confessed life-long anxiety about her own sanity, based on a fear that she might become "like her mother" who had been a patient at Utica State Hospital for the past 30 years. The patient's father was described by the mother as being a shiftless, irresponsible person, like his own father. There was always dissatisfaction in the marriage. The mother became pregnant while she was teaching school and had to leave her position; the father was attending college, and he had to look for a job which he did not find for some time.

The child always demanded attention and would have a tantrum if frustrated in the slightest degree. He began school at six, but was so inattentive, bothersome to other children and teachers, and had such frequent temper outbursts that he was transferred to another school. He learned little but developed a facility in drawing chickens and rabbits. He was unable to adapt to other children. He speech was unintelligible because of his tendency to use words inappropriately; he did not seem to care to be communicative but rather chose to talk to himself.

When he was six years old, his mother had another child. At first, the patient was uninterested in his new sibling, but after a few months became definitely hostile, teasing and destructive in his attitude toward the baby.

At the age of nine, he was seen at a child guidance clinic. He had been attending a special class for two years. In this school, he might scream all day without provocation. On other days he would be very quiet, only to burst out yelling suddenly in a terrified and terrifying manner. He was mischievous and would continually hit other children. It was noted by his teacher that he wrote consistently upside down and backward. He read well, but disliked any interruption; when he finished with a book, he would throw it in any direction. He spelled well but would not attempt arithmetic. He said he saw pictures on the blackboard and walls and would describe fantastic scenes on a blank wall. These ex-

periences seemed more like hallucinations than eidetic imagery. Sometimes he became terrified by the imaginary pictures he visualized. He made fantastic, "out-of-this-world" drawings. He developed an abounding interest in human arms "long, short, fat, and thin." He would pick at the hair on the arm of any available adult. "Arms" became the main topic of his conversation for months. He would never tell his real name when asked, but each time would reply by giving another name. His teachers and parents noted that he had a compulsion to fill up any type of hole, crevice, or crack, in school or at home, with anything handy.

On psychiatric examination in 1940, it was the psychiatrist's impression that the boy was psychotic rather than mentally defective, and a diagnosis of childhood schizophrenia was made. His behavior was similar to that already described. He repeatedly used the word "mouth" in sentences, and made constant reference to sex organs. He talked to himself in gibberish. He sang songs, the individual words of which were intelligible. Psychometric examination at that time revealed a chronological age of 10-7, mental age 8-8, I. Q. undetermined. The performance was uneven, basal age 6, rote memory age 14, similarities at 12 years, rhymes at 9 years. He read well. It was recommended that he be admitted to the children's group at Rockland State Hospital for observation and study.

Physical examination on admission revealed a tall, obese boy, age 11 years, one month; height 5 feet, one inch; weight 112 pounds. He was precociously developed with large, well-formed genitalia and abundant pubic hair. There was a tendency to adiposity at the hips and breasts. Heart, lungs, and abdomen were not abnormal.

Neurological examination was difficult because of his uncooperativeness. His gait was normal except for apparent mannerisms, such as posturing with his hands and walking in a mincing way. The deep reflexes were generally increased but not recognizably unequal. There was defective plantar flexion bilaterally, with a tendency to inconstant fanning of the small toes on the right and a similar inconstant Rossolimo on the same side. Abdominal reflexes were present, but slightly less active on the right; cremasteric reflexes failed to be elicited on repeated testing. The cranial nerves

revealed no abnormalities. Sensory examination was unreliable, but there were no obvious gross defects.

Psychiatric observations confirmed previous descriptions. He was confused, distractible, and dissociated. Speech was high-pitched, monotonous, and sing-song. He was destructive, made frequent references to anal and genital matters, alternated between silly gleefulness and raging tantrums. Sometimes he would go into a period of prolonged silent depression. He picked at the hair on the nurse's arm, pushed, and tormented other children. He probably hallucinated. He said he saw his father every day at lunch, when the father was really nowhere near.

Psychometric examination was extremely interesting in the light of previous tests. Among the results were: Vocabulary, form L, mental age 8 years; Revised Standford-Binet, form L, chronological age 11-4, mental age 11-11, I. Q. 105; Arthur Performance Scale, chronological age 11-4, mental age 9-3, I. Q. 82. It was estimated that his true level of intelligence was better than average. His intellectual assets included a remarkable memory span, unusual reading skill, and a high quality of vocabulary usage. Outstanding, were the serious lack of judgment, disturbed association processes leading to bizarre productions, and an almost complete inability to persist toward a goal in the face of various obstacles.

Rorschach interpretation was handicapped by the patient's distractibility and negativism. He yielded many irrelevant responses and would not respond to all the cards. The impression was that of the presence of a schizophrenic process. Organic factors were not ascertained. He did not cooperate with the graphic Rorschach procedure.

Several *electroencephalographic records* were obtained. The outstanding characteristics included the presence of many slow waves of moderate amplitude of 3 to 5 cycles per second activity in the frontal area. There was nonequivalence on the two sides of the head with the brunt of the abnormality on the left, anteriorly. The electroencephalographic interpretation was diffuse electrocortical dysrhythmia, predominantly frontal and greatest on the left.

A *pneumoencephalogram* was performed a month after admission. The right lateral ventricle was found to be much smaller than the left which appeared to be dilated in both its anterior and

posterior aspects. Lateral views revealed dilatation of the posterior horns and irregularity in the contours of the bodies of the ventricles. Left lateral stereoscopic views revealed displacement of the ventricles, thickening of the posterior clinoids and enlargement of the posterior horns. These findings were corroborated by Dr. Cornelius Dyke.

Discussion. This is a child whose heredity is poor with a history of instability in both parents and grandparents—a psychotic maternal grandmother and a maternal grandfather who died of brain tumor. Although the child was obviously rejected since birth and could never receive adequate emotional satisfaction from his mother or father, he never sustained any severe psychic traumata. There was a doubtful conjectured birth injury and a head trauma at five years without evidence of cerebral injury at the time. There have been no striking infectious diseases. The personality and behavior abnormalities certainly started at a very early age and were unequivocal at the age of three years. When first examined at the age of six, the child was considered mentally defective but during subsequent years his I. Q. rose. Whereas, early I. Q.'s indicated low grade mental deficiency, the most recent I. Q. was 111. The Rorschach impression was schizophrenia, likewise the clinical psychiatric impression was schizophrenia. The neurological examination yielded a few scattered motor signs suggesting frontal and prefrontal involvement on the left side of the brain. The electroencephalographic impression was diffuse electrocortical dysrhythmia, predominantly frontal-central, greatest on the left. The pneumoencephalogram revealed a dilatation of the left lateral ventricle yielding an impression of cortical dysplasia.

Case 2, *B. F.*

B. F., an eight-year-old white boy, of Russian descent, was admitted to the children's group on December 5, 1937, because of seclusiveness, infantile behavior, confusion, and inability to get along with other children.

He was born in New York City on September 20, 1929. The mother's pregnancy was uneventful, labor was slightly prolonged, but delivery was normal. He was a small, sickly baby, breast-fed for only a few weeks before being placed on a formula. There was

no difficulty with weaning. When he was a few months old, he was brought to live with the maternal grandmother because the mother felt she was "too young to be tied down with a child." During a stay of a year and a half at the grandmother's house, B. F. received constant attention and coddling. Slow psychomotor development is shown by his failure to talk until the age of 22 months.

At 17 months, he suffered three convulsive seizures, apparently concomitant with teething. At that time he was said to have had a temperature of 103 degrees and shortly afterward contracted a cold which lasted 10 days. At four years, he had pneumonia, which was preceded by several convulsions. His temperature was above 104 for several days, during which he had a few short periods of unconsciousness. At five years, he underwent a tonsillectomy, and later had the usual and uncomplicated childhood diseases. None of these illnesses was very severe.

The family history revealed maladjustment rampant throughout the maternal and paternal lines. The parents were unhappily mated, constantly fighting in the presence of the child. The father seemed dominated by the mother. He was a short, ineffectual man, ridden with neurotic facial tics and body movements. The mother charged he had "spoiled" the child. The mother was a tall, unattractive woman, nearsighted and having a very poor complexion. She had a very unhappy family life and openly described her hatred of her father. She had married in order to escape from home. She was very erratic, given to tantrums, admitted that she constantly nagged and shouted at the child. The maternal grandfather was described as a "vile, unscrupulous man" who gambled, drank, and neglected his family. The maternal grandmother was said to have a violent temper but to be "well-meaning." The paternal grandfather was a weak, ineffectual man, dominated by his wife. She, in turn, was a dull, selfish woman who tried to run the lives of her children. The patient has one sibling, a girl four years younger than himself, described as normal but irritable, willful, and possessing many food fads. The mother would often say to the psychiatrist, "My daughter is your next case, she's terrible."

As a small child, the patient was always seclusive, avoided other children and often wandered away from home. At five years of

age, he was sent to kindergarten where he did not mingle with the other pupils but cried and whined if any of them approached him. At six, he entered grade school where he was helpless and complained of being teased and molested. He became a sort of unwitting clown in class and annoyed other children, who retaliated. He grew more and more seclusive, daydreamed continuously, displayed a vivid imagination, and related wierd tales. He began to grimace, blink, and cough. The mother attributed this disorder to the child's copying of his father's mannerisms; the father attributed the boy's difficulties to the mother's improper care and rejection.

Physical examination on admission revealed a well nourished but poorly developed child. There was slouchy posture and a suggestive hypopituitary habitus: undescended testes, a small short penis, tapered fingers and toes, rounded hips, and feminine-appearing facies. Heart, lungs, and abdomen were not abnormal.

Neurological examination was performed on May 5, 1941. There was an abnormal plantar response on the right, and generally increased reflexes. Nonequilibratory coordination was clumsily performed, especially the right finger-to-nose test and the right finger-to-thumb test. The child was right handed. There was a suggestive right supranuclear facial weakness, and the right palpebral fissure was definitely wider than the left. The left shoulder was held consistently lower than the right, and the gait was awkward and shuffling. The latter findings were interpreted as mannerisms. The tics and spasms of the facial musculature seemed exaggerated when the child was being examined or observed although they were present at other times, too. Any anxiety tended to exaggerate them.

Psychiatric examination revealed an extremely self-absorbed, withdrawn, unhappy child. He appeared apathetic and inadequate in his responses to the outer world. He seemed to pay no attention to what was asked of him but either stared straight ahead or read a comic book. He was unable to talk about himself or his problems, was antagonistic and hostile to adults and children, and expressed paranoid ideas. He probably hallucinated, as he was frequently observed talking to himself and asserted that he heard whispering but could not understand what was said. He was

afraid of even the youngest, weakest child. If his daydreaming was disturbed, he became irritable and whining. Besides the previously noted tics, a periodic twitching of one side of the face was observed. He also had a mannerism of touching one finger to the nose rapidly over and over again.

Psychological examination in October, 1937, revealed an I. Q. of 116 (Stanford-Binet). Another test in January, 1938, was 91, but it was recognizably unreliable because of the child's emotional state. A year later, the I. Q. was 112, but again it was certain that he was not functioning at the optimum level of his ability.

A Rorschach interpretation, March 7, 1940, indicated that the boy had superior ability, probably far above all obtained test scores but his severe emotional disturbances would not permit its full functioning, that there was a great break in the personality structure, a marked withdrawal from reality, indicating a schizoid but not definitely schizophrenic picture. Another Rorschach was interpreted on June 15, 1941, and made an interesting comparison with the one taken 16 months previously. It was of the same general character, but the changes were consistently in the direction of a poorer adjustment to reality and indicated more fertile ground for a frankly pathological reaction.

His *graphic Rorschach* productions revealed a high level of autistic activity. Stable or creative inner activity declined so that effective use of his energies decreased. None of the Rorschach records was interpreted as indicative of organic brain disease. There were evidences of increasingly great personality maladjustments and diversion of energy in fantasy channels, with increasingly poorly related wishes to reality.

Electroencephalographic records were taken on several occasions. The results revealed the presence of slow waves, 3 to 5 cycles per second, dyssymmetry and nonequivalence but no localizable features. The electroencephalographic impression was one of diffuse electrocortical dysrhythmia.

A pneumoencephalogram was performed on May 7, 1941. The lateral ventricles were found to be definitely asymmetric, the left somewhat larger than the right. The lateral and third ventricles

were in their normal positions, and the aqueduct and other parts appeared normal. The pneumoencephalographic interpretation was cortical dysplasia.

The child's *subsequent course* was uneventful. Sometimes he crawled like a baby on the floor. He masturbated openly and compulsively. He whined that nobody liked him and that everybody was "against him." Play therapy was attempted for some time, and other forms of intensive psychotherapy ventured, but the boy was unable to form any attachments, or to make any proper identifications. Although he received much antuitrin-S, his testes did not descend. He was sent home from the children's group after three years and eight months of observation and treatment. He has been followed in the out-patient clinic ever since, and after two years is now being considered for admission to a State hospital.

Comment. This is the case of a boy who was first admitted for observation and study at the age of eight. He was seclusive, inadequate, self-absorbed, had auditory hallucinations, and even at that early stage entertained some paranoid ideas that nobody liked him or wanted him. These paranoid reactions had some basis in reality since he was congenitally rejected by his mother and suffered emotional deprivation throughout his life. The heredity was poor in that the families of both his father and mother were replete with maladjustment. The child's parents were unhappy people, the father inadequate, ridden by tics and mannerisms presumably of a psychogenic basis, the mother extremely hostile and dissatisfied with life in general and the patient in particular.

Early in childhood, apparently during the prodromal period of a respiratory infection, the child had convulsive seizures. This suggestion of a convulsive diathesis was corroborated later when, at the age of four, he had several additional convulsions accompanying the onset of pneumonia. That the convulsions came on before the development of the infectious disease and not as sequelae suggests that an abnormal or susceptible brain structure was already present and that the defective brain structure was not the result of the effect of the infectious agents. There was no history of trauma or birth injury.

The clinical psychiatric impression revealed a schizoid or schizophrenic-like reaction. The Rorschach records were likewise interpreted as indicating a schizoid picture, "fertile ground for a schizophrenic reaction." Neurological examination revealed the presence of scattered signs pointing to some defect in the central nervous system, nonlocalizable, but suggesting that the brunt of pathology was on the left side of the brain. The electroencephalographic findings were nonlocalizable but indicated a diffuse electrocortical dysrhythmia. Pneumoencephalographic findings pointed to a diagnosis of cortical dysplasia with the left lateral ventricle slightly larger than the right.

Case 3, J. L.

Before this child was admitted to the children's group, her case was reported by Dr. Louise Despert in a paper, "Thinking and Motility Disorders in a Schizophrenic Child" (PSYCHIATRIC QUARTERLY, July, 1941), and therefore only a brief account of the history will be presented here.

J. L., an eight-year-old white girl, the only child of native-born Jewish parents, was admitted to the children's group on July 8, 1941. She was referred for observation and possible "shock" treatment because of inability to play with other children, assaultiveness, tantrums, and masturbation.

The child was born in Chicago on January 22, 1933. The baby was unwanted and unplanned for, labor was prolonged, and forceps were used in the delivery. J. L. was a full-term baby weighing seven pounds. She was breast-fed for three months. Psychomotor development was normal. Speech was delayed, and her first words were uttered at 12 months. At three years, her language was limited in that she used very few words for communicating with parents or children, although she really had a good vocabulary. She was toilet-trained at two years.

The family history was rich in maladjustment. The paternal grandparents were withdrawn, indifferent people. The maternal grandfather was unhappy, irritable, subject to sudden fearful outbursts. The maternal grandmother feared "insanity." The father was a seclusive man who had a facial asymmetry, a frontal scar, and one glass eye. The mother was intelligent but aggressive. She

suffered from an anxiety neurosis, feared "insanity," and had hallucinations after her father's death. She would think she saw her dead father lying in the bath tub. She was overanxious, overprotective and sometimes openly sadistic toward the patient.

At the age of three, the patient would hit other children and developed severe repeated tantrums, followed by vomiting spells. At three and one-half, she began to wet and soil. At four, she was admitted to the Psychiatric Institute.

At this institution, she was aggressive, destructive, talked in a rapid sing-song babyish way, ate greedily, smeared food on her face. She wet and soiled, sucked the hem of her dress, and continued to have tantrums.

Physical and neurological examinations and laboratory data showed no abnormalities. There was a palpable spina bifida occulta in the first sacral segment, which was confirmed by X-ray.

Psychometric examinations yielded 96 on Stanford-Binet and 100 on Minnesota Preschool Non-verbal Test. At four years, nine months she would walk blindly, hurting herself, spit profusely, talk to herself and display other bizarre forms of behavior. Her speech contained many neologisms. On several occasions she seemed to be in a state of catatonic excitement with cerea flexibilitas.

At six years, she displayed a constant irrelevant smile, echolalia and neologisms. At times she stared into space as if she were hallucinated. She was excluded from school, the teacher expressing the opinion that the child was "an idiot or crazy."

She was admitted to and discharged from the Psychiatric Institute several times.

On admission to the children's group in July, 1941, *physical examination* revealed no gross abnormalities. *Neurological examination* revealed sluggish pupillary reactions to light, the left pupil being larger than the right. There was bilateral nystagmus on looking to the extreme left; there was defective plantar flexion and a positive Oppenheim reflex on the right. Repeated neurological examinations showed these signs to be inconstant, but there was no doubt as to the presence of scattered signs indicating disease of the central nervous system. The results of *psychiatric examination* coincided with other psychiatric descriptions given in the foregoing.

Psychological tests yielded an I. Q. of 65 on Stanford-Binet, Form L, and 79 on Arthur Performance Scale I; Goodenough drawing-a-man, mental age 4-9, chronological age 8-10. It was the psychologist's impression that the child was functioning on a high grade defective level, but that two striking abilities were present: a remarkable rote memory and excellent arithmetic ability of a rote nature, and that these characteristics indicated a much higher level of intelligence.

Electroencephalographic records were taken on several occasions and revealed 4 to 6 per second rhythms dominant in all leads, showing higher incidence and amplitude after hyperventilation. The electroencephalographic impression was "diffuse electrocortical dysrhythmia, with some features of an epileptic EEG, such as the rate of dominant frequencies and marked hyperventilation effect." EEG's taken at the Psychiatric Institute prior to admission to the children's group were also reported as abnormal.

A pneumoencephalogram was not performed at the children's group because the parents refused permission. However, a pneumoencephalogram done at New York Hospital on March 7, 1941, was reported as negative.

Comment: This is an eight-year-old girl who has manifested schizophrenic-like symptoms since the age of three years. Since that time her symptoms became progressively worse. The heredity is poor with a neurotic, overprotective, rejecting mother, a seclusive father, and maladjusted grandparents. Although this child, like others in this series, was rejected since birth and suffered constant emotional deprivation, she never sustained any obvious severe psychic traumata. As in the first case, there is doubtful history of birth injury but no evidence supporting such a conjecture. The psychometric results revealed a steadily declining I. Q., from 98 to 65 over a four-year period. The affective dissociation, regressive features, and mental deterioration pointed to a psychiatric clinical impression of schizophrenia. The Rorschach impression was schizophrenia. Neurological examination revealed scattered, nonfocal signs pointing to probable diffuse disease of the central nervous system. The electroencephalographic impression was diffuse electrocortical dysrhythmia. A pneumoencephalo-

gram done prior to admission was reported as negative. It will be repeated as soon as the parents grant this permission.

Discussion and Conclusions

The literature concerning schizophrenia in children will not be reviewed here because it was discussed in detail in the writers' previous paper (Psychiatric Quarterly, January, 1941).

In that previous series of seven cases of schizophrenic-like reactions in children, it was found that five cases showed evidence of organic disease of the brain, probably on a hypoplastic basis as judged by the pneumoencephalograms; all seven cases yielded abnormal electroencephalograms. Only one case was adjudged "organic" on Rorschach interpretation.

In the present series, two had definite evidence of organic disease of the brain, probably on a hypoplastic basis as judged by the pneumoencephalograms. In the third case, a pneumoencephalogram was performed elsewhere but was reported as negative.

In all three cases, repeated and careful neurological examinations revealed definite diffuse signs of organic disease of the central nervous system.

In all three cases, repeated electroencephalograms revealed the presence of diffuse electrocortical dysrhythmias.

In none of the three cases did Rorschach interpretation offer organic clues; in each case, the Rorschach impression was schizophrenia or schizophrenic-like reaction.

In all three cases, the family histories were replete with obvious maladjustments in the parents and paternal and maternal lines. In each case, a dominant, overprotective, possessive, basically rejecting mother appeared.

This study offers no conclusions. The temptation to draw conclusions is great, but such inferences are not scientifically warranted until many more cases can be studied over a period of many years. However, it appears that one could be justified in saying that organic brain pathology is often associated with schizophrenia or schizophrenic-like reactions in children and should be suspected and carefully sought for.

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POSTHOSPITALIZATION SUPPORTIVE PSYCHOTHERAPY

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The evaluation of psychiatric therapy is traditionally in terms of recoveries and improvements. To this, the writer contends, should be added a third criterion, to wit, the maintenance of an optimum level of adjustment. This is the problem of extramural supportive psychotherapy in the posthospitalization period.

If the mere maintenance of an optimum level of adjustment appears like a retreat from the original objectives of psychiatric treatment it might be well to draw a parallel to other chronic clinical entities. The cardiologist does not hope to cure a patient of a chronic valvular heart disease. He keeps his patient compensated and as comfortable as possible, and, in this, performs a great service for his patient, often prolonging his life for many years. If one fully recognizes the fact that beyond a certain point—whether one thinks of schizophrenic psychopathology as functional or organic, a meaningless dichotomy in the long run—it ceases to be reversible, it must be conceded that for patients whose pathology has reached the stage of irreversibility only the maintenance of a level of optimum adjustment is possible. In accomplishing that much, psychiatric treatment will have rendered a service fully comparable to the work of the cardiologist with his case of chronic valvular deficiency.

Function of Hospitalization

As the period of hospitalization is a very closely-allied phase of treatment to that of posthospitalization, its rôle in the total care of the patient needs a clear elucidation. The function of mental hospitalization is a concept still in a considerable state of flux. The mental hospital began with the sole idea of sequestering the patient, removing him from society. In one form or another, this custodial function still permeates the state hospital atmosphere, and progress toward a newer conception of its function is still largely halting, or is blind groping. It may, therefore, be of some service to give as terse and clear a conception of its proper function as possible.

These functions may be enumerated as follows: (a) Removal of the patient to a neutral environment wherein external stresses and irritants are reduced to a minimum; (b) Study of the body economy, that is, physical condition, including peculiarities of physique and constitution and their relationship to the mental disorder; (c) Treatment of any organic and toxic factors encountered; (d) Assay of personality assets and defects of personality, e. g., work of psychologist—psychometric examinations, aptitude tests, Rorschach tests, etc; (e) Work of social service department, and possible therapeutic intervention with relatives at the direction of the psychiatrist; (f) As complete a study as possible of the psychodynamics of the psychosis and of the psychodynamic organization of the patient's personality—the hub of the patient's entire treatment and the basis for any future planning; (g) Intensive psychotherapy, group as well as individual, based on a knowledge of the patient's psychodynamic makeup; (h) Regulation of the entire life of the patient during hospitalization, e. g., therapy through recreation, occupation and reeducation; (i) Some comprehensive plan for the posthospitalization supervision and therapy; (j) Release from the institution at the optimum point of improvement consistent with extramural adjustment.

Posthospitalization Therapy

1. *Ego-support Adapted to the Needs of the Patient*

Psychotherapy of posthospitalized patients, as with any other patients, must be guided by individual indications. With most schizophrenics, there is usually a weak, very much threatened ego. To expect such a patient to assume the usual responsibilities of the average person without any unusual assistance is no less unreasonable than to expect the cardiac patient to resume full-scale physical activity as soon as his defect has been compensated. Even moderately conservative opinion holds to the belief that no patient can be considered "recovered" from a major psychosis within an interval of five years of good adjustment following the psychotic breakdown.

The vast majority require aftercare, first because the equilibrium achieved by the patient is usually unstable; second, because

the patient usually returns to the *milieu,* which, in all probability, contributed to his psychosis in the first place. The rôle of the family and its effect on the course of the patient's mental disturbance has been noted by many observers, but a most emphatic pronouncement is offered by Federn* who states: "No patient can be cured unless his family wishes it, even less in the presence of the family's unconscious or conscious hatred. No physician can cure any severe case when bed, rest and care are lacking, or when, intentionally or not, antagonisms develop to the task of bringing back the psychotic ego to normality and reality. . . .

"It is not at all astonishing that most psychotics relapse at home or elsewhere when left without the continuous support of transference. Every psychosis is consciously or unconsciously focusing on conflicts or frustrations in family life. Unless these conditions are changed the cure of psychotics turns out to have been Sisyphean labor which ends in hospitalization or foster-family life . . ."

The foregoing strongly highlights the rôle of supportive therapy. The psychiatrist must have an accurate appraisal of the patient's personality and the essential character of the conflict so that his therapy may directly meet the conditions encountered. In most instances, however, in schizophrenias of any duration, it is unwise to probe deeply. With these patients, the ego is too threatened and too insecure to withstand any searching analysis. What the ego needs is reassurance and bolstering. How this works out may be seen in the following example.

Case 1

E. M., a tall, rather asthenic, good-looking young woman of about 25, had had two previous hospitalizations in mental institutions. On the admission reported here, her behavior was extremely childish—sympathy and attention-seeking.

She was the first child in her family. History discloses a marked rejection by an ambitious, dominating mother. The father was rather weak and ineffectual, and was diabetic. An example of marked hostility toward the patient by the parents and especially the mother, occurred when the patient was in her last year of high

*Federn, P.: Psychoanalysis of psychoses. Psychiat. Quart., 17, 1943.

school. A classmate of whom the family did not approve took the patient to a school dance. When, later, the girl was late with her menstrual period, the mother immediately concluded she was pregnant and forced her to stay indoors. The family doctor refused to perform a curettement. According to one informant, a curettement to induce abortion was actually done by another doctor.

E. M. had been frequently whipped by parents and left sore and bleeding.

Her younger sister capitalized on the situation by taking pains to make a good record at school, a fact to which the mother often alluded in making disparaging comparisons. Later, the patient failed in her college work.

The patient had now established residence in Illinois, having left her home in Michigan where the family resided and where she had previously been hospitalized in Michigan state institutions. When the mother called long distance she made inquiry about the comparative merits of Michigan and Illinois state institutions; and when assured that a transfer to a Michigan institution could be effected, she replied, "Oh no, we wouldn't want her close to home. We wouldn't want the disgrace."

Later, the mother visited the doctor at the hospital concerning permission for a gynecological operation. The mother is a middle-aged woman, nattily dressed. She is uneasy in her conversation and probably rather guilt-ridden. She wishes to know if the operation is necessary or only an "experiment," and "would an anesthetic be used?" Her greeting of her daughter was noticeably cool and distant.

During this hospitalization, the patient was interviewed frequently and obtained a very good insight into her problems.

After her release from the institution, she returned for weekly interviews. It was obvious from the start that her adjustment was a precarious one. She had been extremely sensitized to psychic traumata. At her job, when her supervisor calls attention to a minor error in her work a veritable crisis impends, and she requires much reassurance; she speaks of looking for another position, and the reasons for her dissatisfaction have to be painfully explored. At such times, the therapist can tell as soon as she steps through the door that all is not well, for the facial muscles show

an increased tonicity, and strain is apparent. In these instances, it is shown that such occurrences have been equated with maternal rejection, and her special sensitivity is pointed out.

The important element in the therapy is the ego-support, for E. M. turns to the therapist toward whom she has made a good transference for the protection of her very insecure, threatened ego.

Another crisis relates to the fact that while at the hospital she had had on one occasion a doubtful Wassermann reaction. A spinal puncture and repeated serology had been negative. However, because of the good rapport with the therapist, reassurance on this point averts a psychotic breakdown which always threatens as a probable consequence of any of these crises.

Another crisis revolved around the young man to whom she was engaged and who is in the service. She had not heard from him. Once he had served a term in the "brig." She feared to learn of his whereabouts, and yet wanted very much to hear from him. Nevertheless, because of the support she had received, she summoned enough courage to write to the adjutant-general, and learned he was at Leavenworth, whether as a prisoner or on duty was not stated; he could have written and, since he had not, she was ready to dismiss him from her thoughts.

At this time, the patient got her annual vacation and went home for a visit.

Upon the first interview after her return she came in in a happy frame of mind. She had been promoted at work and had received a raise, which occurrence could now be added to the capital and backlog of self-assurance which the patient was gradually building up.

But, about her visit, she reported that she often had had apparently unaccountable crying spells while at home. In relating the events of the visit, some reasons for these attacks became apparent. They related to the rejecting attitude of her mother. As an example, the patient stated that at one time, apparently apropos of nothing, the mother had asked whether she knew that Leavenworth was a military prison where soldiers guilty of military offenses served their sentences. The mother would not be more specific. Naturally, the patient could not believe her mother's speak-

ing of Leavenworth at this time was mere coincidence and unrelated to herself. Her boy friend had probably written to her mother, or the mother had found out his whereabouts through some other source. But, significantly, the mother reposed so little confidence in the patient that she would not disclose details, probably because in the mother's opinion her daughter "could not take it." Yet the oblique reference itself, the patient felt, was traumatizing and also the distance between herself and mother thus interposed.

How sensitized to psychic traumata this patient is, how threatened and insecure, can be seen in the remark she addressed to the therapist during one interview: "Some people may think I'm dumb, and sometimes I think you think so, too!"

In the main, it is logical to believe that without the transference to the therapist, the relief which the patient obtains from psychic catharsis, and especially the ego-support and reassurance from the therapist, she would long ago have suffered a relapse. The treatment has kept the patient compensated, so to speak, largely because of the ego-support.

2. *Deeper Psychic Exploration Only with Utmost Circumspection*

Generally, in the schizophrenic, the ego is too threatened and too insecure to attempt a deeper exploration. What may happen when that is attempted may be indicated by the following case.

Case 2

J. S. is a 23-year-old white male. His father, born in Lithuania, studied for the rabbinate, but came to the United States at the age of 17 and became a mechanic. He traveled around the country on a motorcycle, but settled down in Chicago in 1914, was married and opened an auto radiator repair shop which prospered. Then came the depression and a reduction in the volume of his business. Though warned by his attorney to retrench, he increased his advertising expenditures. Finances deteriorated rapidly. He lost much of his property. At this juncture, the patient's father began to write and have printed pamphlets with such titles as "Democracy," "Eugenics," "The New Democracy." The patient, about nine years old, would help his father sell these pamphlets. The father now developed ideas about his having been defrauded of

his property; he started suit against the Standard Oil Company for opening a gas station across the street from his shop. While he was being evicted he refused the offer of temporary shelter and assistance, saying he was capable of earning millions, was the inventor of a number of well-known patents. The patient's father was finally committed to a state hospital with the diagnosis of dementia præcox, paranoid type. The mother, also, has had a period of hospitalization in a mental institution.

The patient and eight siblings were cared for in different foster-homes. Three years prior to his commitment, it was noticed that the patient's behavior was peculiar. He jumped from his bed one night, laughed hysterically and acted "silly." Even before this episode, four years antedating it, a psychiatrist's report (1934) was even more revealing. To quote: "We do not feel that this boy will make an outstanding achievement, but we think he will make a better than average place for himself. During the past year in particular the boy seems to show evidence of following the same paranoid pattern of his father." This psychiatrist recommended that "J—— be handled carefully to avoid the precipitation of a breakdown."

Following a period of persistent doorbell ringing, J. S. was committed to the state hospital. Here, he was found delusional, "levelled-off;" had grotesque mannerisms and grimaces. Shortly after admission, he told the doctor that he felt obligated to take his father's place and look out for the family.

He was placed on insulin therapy from May 13, 1941, to August 1, 1941, with a social recovery and was paroled to his sister and brother-in-law.

In subsequent interviews, it developed he had formed a very strong identification with his father. He stated he had thought his father was a "great fellow." At another time he said his father was his idol, and recalled how the father had taken the children to shows and how, as a hobby, he often cooked for the family. He was very companionable with his children; they frequently went on outings. Then, when the patient was about nine years old, this happy life suddenly exploded in his face. At the time, he stated, he couldn't understand it. "I used to think that what happened

to him could happen to me. That's why I leaned to the study of social problems."

J. S. had expected to go into law and some day vindicate his father. His foster-father, a kindly, elderly, retired man, had been a member of the Socialist Party and finally got the patient interested in Socialism. Now, the patient related, he thought he understood how his father had been defrauded. He wrote about these ideas to his father and received a stinging reply, that he (his father) was not a Socialist, and the very hint of it was repugnant to him. He was outraged that his son should have taken up such an obnoxious creed. No, he was not a victim of the class struggle, and his financial difficulties could not be laid to the capitalist system in which the father was an ardent believer. This reply was a shock to the patient, who related how he had kept his father's letters over a period of four years, neatly tied up in his dresser drawer and that he would peruse them frequently. Then, in a fit of despondency, he concluded he had done all he could for his father and threw the letters away. He later suffered from remorse and guilt for this act.

Two or three weeks after his release from the hospital, he came for an interview acting in the silliest fashion. His clothes were crumpled. He had a number of unusual-looking thin stogies with numerous twists in them protruding from his breast pocket. He laughed and grimaced in the most bizarre manner. He kept puffing industriously on one of the stogies, spilling cigar ashes over his clothes. When asked about this, he explained that he had bought the stogies in a Mexican store. With him, he had a handbill in Spanish announcing a Mexican mass meeting and entertainment. He was going to attend this meeting, explaining that he desired to associate with Mexicans because Mexicans "are lower than me. Contrasted with them I seem higher." It all appeared hopeless; the sister was advised to return him to the hospital. However, she desired to wait and see what would happen, and the patient continued to come for his weekly interviews.*

After several weeks, he regained his equilibrium and went on as before. He was now working in the stock yards on a late shift, had

*Up to this point, this case history was reported in Dis. Nerv. Sys., 5:7:209-218, July, 1944.

gone back to college, of which he had completed about a year. His adjustment continued good for a year, and in the first semester he passed all his subjects. In the second semester, he had difficulty with chemistry, and this subject he had to repeat in summer school. He worked hard, studied hard and occasionally suffered from a more or less acute depression that resulted from a pessimistic appraisal of his situation. At such times, he would unburden himself to the therapist about the monotony of his existence and its uselessness, and would receive reassurance and an occasional interpretation of his attitude.

As the pessimism did not seem to improve after two years of care and treatment, and, moreover, as it was obvious that some deep-seated pathology continued to maintain his adjustment on a very precarious level, the therapist, ill-advisedly, resolved to see if he could discover precisely why the patient did not improve further.

Thus, the therapist began to probe. The patient began to talk about Socialism at every interview. Then, as if these discussions were insufficient, he began to write letters about Socialism. This activity began to increase in a crescendo of letter-writing. He began to send four and five letters a day. The therapist realized that these epistles were an attempted seduction of the doctor, but precisely what it meant was not clear. Excerpts from one of these letters read as follows:

> Dear Dr. Klapman:
>
> I was reading Aristophanes. I had finished the introduction and had begun to read the comedy itself. My mind was tired and through it flitted "*The Nature of the Capitalist Crisis*" by John Strachey.
>
> . . . . . .
>
> Marx also points out that the basis of political economy is in industrial capital.
>
> . . . . . .
>
> *Fixed Capital.* . . .
>
> . . . . . .
>
> Means of consumption . . .

> To switch to a different subject, in reading the introductory words to Aristophanes' "The Birds," I noticed that the author observes "The World is a comedy to those who think, a tragedy to those who feel. How true!"

It soon became evident that Socialism represented a kind of ideological bridge between himself and the many father-figures with whom he successively made identification and who in the course of time rejected him. That, at least in part, explains the panic-like compulsive letter-writing of three, four and five letters a day to his therapist, a panic-like attempt to hold the therapist, who, the patient feared, was rejecting him, since he was attempting to probe him.

The following are excerpts noted from an interview on October 24, 1943:

Q. Who is De Leon? (He had been writing a great deal about De Leon in his letters).

A. "He's a professor. I wanted to write a book about him. He is the author of the industrial union concept. You know I met K——. K—— is the head of the Jewish Children's Bureau. He told me he was a Socialist, but father told me in his letter K—— was holding his nine children. (Rejection by another father-figure.)

"I saw Morris Hilquit and he looked like K——. Hilquit, a millionaire and a Socialist I couldn't understand. I saw Debs' picture. I thought he was like Lincoln. (The patient had a silly mannerism of jutting out his jaw like a boxer. Once, when asked about this, he had explained that that gave him a resemblance to Lincoln.) Hilquit hated De Leon. De Leon threw Hilquit out of the Socialist Party."

It was pointed out to him how his father-surrogates always seemed to disappoint him just as his own father did in refusing to recognize Socialism as the cure of his economic difficulties. He states:

"All my life I have had it intimated to me indirectly about my father. I read a book that said heredity is the dominant thing; environment secondary. That's why I got so interested in Socialist ideas, because they show it's more economic.

"When I think of my father, I think of a man who was vigorous physically and intellectually. I know when he was down and out he was fighting the world's wrong premise.

"If he could only have made the transformation of fighting for the elimination of poverty and not try to remain in his own class.

"My father used to write me long letters; wanted me to get his property back. Every lawyer we tried couldn't handle it, so I finally concluded the only way he could get his property back was under Socialism.

"When I think of Socialism and my father I get sexually stimulated and abuse myself." (Note the erotization.)

And excerpts from October 31, 1944:

The therapist showed the patient how his compulsive letter-writing was an attempt to hold the therapist, whose loss was not at all imminent.

Patient: "I got to be emotionally dependent on something. Life is a complexity. I don't want to lose contact with life.

"Something in me wants to end up as nothing. I know Mr. Berg (foster-father) told me: 'Your life will be tragic.' "

Q. And even to become optimistic is a betrayal of your father?

A. It is. To please you, I hope for the best. I don't want to hurt you. I don't want to hurt anybody who has been nice to me.

Q. You think to succeed in life and be successful as a chemist would be to betray your father.

A. I don't want to be anything. I don't want to be nothin' but a nothin'. I want to be an abstraction.

Q. In other words, whenever you go to school and there is a danger of getting out of the proletariat, you feel you're betraying your father?

A. (Laughs sheepishly.) That gets to the root of it, all right. There is no doubt there is a father identification.

The patient's behavior subsequently became so disturbed; there occurred such a marked recrudescence of all his former symptoms that he had to be rehospitalized.

It seems fairly certain that the therapist's probing had much to do with disturbing his relationship to the patient. In this instance, where the ego was so weak, insecure and threatened, this probing should not have been undertaken.

3. *Supportive Therapy Must Be Continued Over a Long Period*

If the patient shows no marked tendency toward recovery from the disease process, there is little else to do but to keep up the supportive therapy, just as the cardiologist must perforce continue to rely on bed rest, digitalis, diuretics, etc. Any more or less profound probing can be safely attempted only when some great degree of recovery from the schizophrenic process has occurred. The foregoing case reports also exemplify the need for long-continued contact with the therapist. To this rule may also be added another subsidiary rule. The therapist who treats the posthospitalized patient, by making a thorough study of the patient's relations to his immediate family, can often discover the sources which retard the healing process, and may be able to do something about it.

4. *Posthospitalized Patients Should Be Seen Frequently and Regularly*

In their daily lives, the traumatized patients are exposed to minor frustrations of a kind that another individual scarcely notices. In the postpsychotic, such a situation may be the beginning of a panic state and flight from reality. Seeing his therapist, toward whom he has made a good transference, is like holding on tight to his ties with reality. If the patient does not see his therapist for any great length of time, this period may be sufficient for the recurrence of the acute psychotic state.

This aspect of posthospitalization would appear to find ample corroboration in the reports of civilian war casualties in London. If a patient was immediately seen after the accident or bombing, catharsis and abreaction obtained, and then bed rest given, complete recovery could be obtained in most instances; but if the patient were allowed to go a week or two after the incident, the neurotic symptoms tended to become fixed and treatment more difficult.

Summary and Conclusions

This paper attempts to call attention to the fact that the patient released from the mental hospital is not a completely-solved social, psychiatric or economic problem; the number of such patients in extramural society is by no means inconsiderable. Further treatment is essential. Several guiding principles are set forth and two case histories are given by way of illustration.

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THE CLINICAL MEASUREMENT OF ANXIETY

An Experimental Approach

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The Problem of Anxiety

The aim of this study is to present an objective method of appraising and diagnosing anxiety. So far as the present writers know, no such technique is at present available. The need for one is, however, obvious, since anxiety is admittedly not only the central problem in most of the neuroses and psychoses, but a manifestation of maladjustment or temporary difficulty in many situations of everyday life.

Before presenting the method and the material from which the results reported here have been obtained, a brief review will be given of some of the more commonly cited concepts of anxiety. The aim here is not to enter into a theoretical discussion of anxiety so much as to find a conceptual basis for its objective evaluation and measurement.

The most commonly referred to theory of anxiety—at least in psychiatric circles—is that of Freud. According to Freud,[1] anxiety is the individual's response to threats to the ego, caused by the repression of sexual impulses. This neurotic anxiety, he distinguishes from the normal reaction of fear, which is a defensive response to external danger.

Two other theories derived from psychoanalysis deal with the problem of anxiety. According to Rank,[2] anxiety is the continued "abreaction" of affective tension originally occasioned by the "birth trauma." Adler[3] considers anxiety primarily an affective state resulting from inferiority feelings and secondarily a pattern which the individual uses to satisfy his needs and to escape frustration. Horney[4] combines the Freudian and Adlerian concepts with sociological ideas to give a socio-psychological interpretation of anxiety.

The nonpsychoanalytical concepts are represented by Cannon,[5] whose idea of anxiety is primarily psychophysical, and by McDougall,[6] who sees in anxiety a complex emotion caused by a conflict between hope and despondency. Allied to them, are theories

developed by military psychiatrists[7] who explain acute anxiety in syndromes like "combat fatigue" and "flyer's fatigue" as due to the failure of the individual's ability to repress or suppress normal fear reactions.

All these theories attempt an analysis of anxiety by starting from a description of certain psychological situations in which, or as the result of which, an individual may be expected to develop anxiety. They do not fully explain why equally threatening dangers generate anxiety in one individual and not in another and why there are among normal as well as among neurotic individuals great varieties of reaction to the same situational danger. Such an insufficiency is due in part to the fact that the foregoing theories are concerned with anxiety as a phenomenon rather than with the personality structure of the individual which gives rise to it and more specifically with his level of personality integration.

The present writers accordingly propose as an operational concept what they should like to call the "disintegration concept of anxiety." Under this concept it is assumed: (1) that every individual tends to reach a level of integration maximal for himself; and (2) that he seeks to defend the particular level he has attained against any threat or danger, because any lowering of this level constitutes a vital injury to his ego. Accordingly, anxiety may be expected to arise whenever the individual feels threatened not only by actual danger, but by any situation which threatens his personality as a whole. In both instances, the individual reacts with a state of general alertness and mobilizes whatever defenses he has to avert any and all disintegrative forces.

Since psychological disorganization and motor incoordination are easily observable and objective manifestations of anxiety, it seemed reasonable to assume that one could obtain a projection of the integration level of an individual by placing him in a nonhabitual or surprise situation and by investigating his integrative behavior and his motor productions in such a situation.

On this assumption, one might expect that the poorly integrated personality, always prepared and ready for a defense of the self against any threat, would also be greatly disturbed on the motor level and project his helplessness and anxiety in the form of specific graphomotor disturbances. Such disturbances do in fact oc-

cur; and their psychological analysis permits, as the writers will show presently, an evaluation of the specific conditions which gave rise to them.

Test Procedure and Apparatus

In order to measure anxiety along the lines indicated, the writers made use of a simplified mirror drawing test and devised an apparatus (the "Katoptograph") which permits one to obtain an objective record in less than six minutes.

While the technique of mirror tracing is familiar, it is perhaps important to point out an essential difference between mirror drawing and mirror tracing, which is often referred to under the former term. Mirror tracing is the form of the experiment that has generally been used in experimental psychology (Starch, Snoddy, Weidensall, Louttit)[8] and usually consists of making the subject follow the outline of a geometric figure, generally a six-pointed star, while looking at it in the mirror. The writers' test is actually not a tracing, but a drawing test and it was their aim *not* to provide for the subject any cues or continuous points of reference for his performance.

The present test consists of two parts. Part I requires the drawing of the diagonal of a square of which only the lower right and the upper left vertices are indicated on the test blank (See Figure 2). Part II requires the successive joining of five points distributed irregularly over the space of the blank, followed up by the connecting of two additional points which are screened from the field of vision (See Figure 3). The drawing is done with an ordinary, but well sharpened, pencil about four inches long.

Although there are a number of mirror tracing apparatus available, it seemed desirable to have an instrument which would combine simplicity of construction with special suitability for the test procedure. The apparatus to which the writers have given the name "Katoptograph" (Figure 1) consists of two plywood boards (10 x 12 inches), articulated by means of hinges so that when not in use they can be folded together and carried in a briefcase. The mirror (7 x 7 inches) is mounted centrally on the inner face of one of the boards and the adjustable screen is attached to the other board.

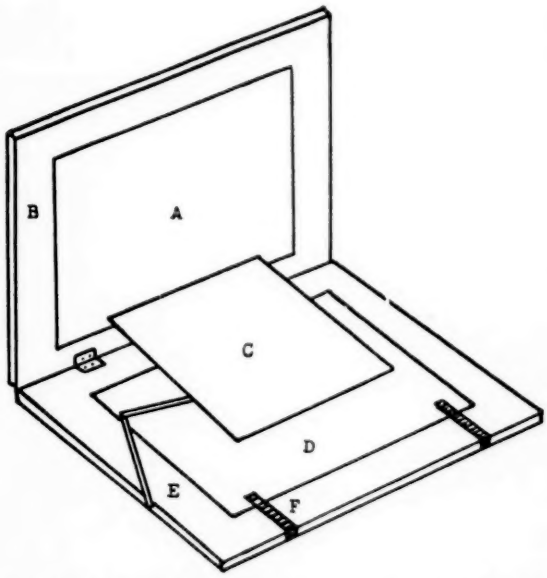

Figure 1. The Katoptograph. A, mirror; B, mirror-board; C, screen; D, test blank; E, drawing board; F, metal clamp.

Administration and Directions

The test is administered in the following way: After the subject has been seated comfortably in front of the Katoptograph, he is informed that he will be asked to do some mirror drawing. He is shown a sample of Part I of the test blank and told that he will be required to draw a straight line from point 1 to point 2 and to do this while looking in the mirror. He receives the short pencil, and his hand is guided by the examiner to point 1. After the subject has found point 1, he receives the following instruction: "When I say 'Go,' draw a straight line from where the pencil is now to point 2, as quickly as you can and without at any time lifting the pencil from the paper." The subject then receives the signal "Go" and is permitted to continue his effort to draw the line until he either has reached his goal or has worked at the problem for three minutes.

After completion of Part I, Part II of the test blank is exposed in the mirror, and the subject is instructed as follows: "When I say 'Go,' draw as quickly as you can a straight line from point 1

to point 2, then from point 2 to point 3, etc., until you reach point 5. Remember that at no time may you lift the pencil from the paper." When the subject has reached point 5, the examiner asks: "Do you see point 6?" After having received an affirmative answer, he places a screen between the subject's eyes and the mirror and says: "Now go to point 6 from memory." As soon as the subject indicates that he thinks he has reached point 6, the examiner lifts the pencil in the subject's hand from the paper and places it on point 6. Then the examiner removes the second screen, permitting the subject to locate point 7 in the mirror, replaces the screen and says: "Now go to point 7." After the subject has completed Katoptogram I and II (K I and K II), the entire test is repeated immediately.

The experiment as outlined has been administered to some 300 subjects, roughly 150 normals and 150 nonnormals (ranging from mild personality disturbances to severe anxiety neurosis and forthright psychosis). In this preliminary paper, the writers wish merely to present and discuss the general results, the fundamentals of interpretation and the characteristics of the individual performance which enable one not only to detect the existence of anxiety, its level, intensity and control, but also to appraise a variety of basic personality traits which either enter into, or modify, or are modified by, the subject's anxiety.

The Criteria and Fundamentals of Interpretation

While detailed information about the katoptographic criteria and the technique of their interpretation will have to be reserved for a more extensive publication, the writers wish to outline in this paper some of the quantitative and qualitative scoring categories founded on the linear and motor aspects of the obtained responses.

The graphomotor categories which are objectively measurable and which are used here as quantitative indicators are time (T), distance (D) and the time-distance-ratio (D/T). Generally, subjects with strong anxiety tension present long time scores. Sometimes the anxiety tension is so great that some individuals become "paralyzed;" that is to say they are completely unable to proceed with the task within the time limits.

Subjects may connect one point with the other by straight or nearly straight lines or proceed in circuitous and deviating paths. The distance required by the subject, measured to the nearest half-centimeter by a precision distance recorder, indicates to what degree the individual is able to control his anxiety.

Finally the relation between the time and distance scores is important. On the basis of a single dichotomy in each, one obtains four possible combinations:

Short Distance/Short Time = SD/ST
Long Distance/Long Time = LD/LT
Short Distance/Long Time = SD/LT
Long Distance/Short Time = LD/ST

The significance of these relationships varies with the magnitude of the ratios and may be associated with different types of personality structure under special consideration at the attained integration level. Provisional norms have been established.

In addition to the foregoing, the writers have found no less than 14 other basic categories that may be used in describing a subject's katoptogram. The following are the most general and are perhaps sufficient to indicate the graphomotor principles they employ.

Graphomotor Block (See Figure 6). This describes a paralysis-like inhibition of the subject and appears on the blank as an accumulation of abortive pencil strokes within a relatively small area. A block always presents considerable density, but the direction of radiation of the strokes is variable. Block expresses, if it occurs right at the start, basic or endogenous anxiety—of considerable intensity and accompanied by a neurotic form of helplessness.

Graphomotor Complex (See Figure 7). This is a variant of the block, indicating a lower degree of anxiety tension. It is less dense, and is usually met with in the middle rather than at the beginning of a subject's drawing.

Segmentation (See Figure 4). This is indicated by the number of linear interruptions, stops, cuts and breaks occurring during a performance.

Spread (See Figure 5). This designates amplitude of the graphomotor response; it may be extensive or retensive, unilateral or bilateral.

Field-Distribution. This is indicated by the specific regions of the available space, which are covered by the performance.

Pencil Pressure. This may be appraised qualitatively by inspection or evaluated quantitatively by means of a self-recording pressure-scale.

Atactic disturbances. These include tremor, jerkings, incoordination, discontinuity, etc., which can be observed in the performances of even neurologically normal subjects, and are related to specific types of personality disintegration.

Blind-drawing. This involves the subject's performance on K II without visual guide and takes into consideration the direction and distance of the line so drawn, as well as the delay between signal and response.

Comparison of test with retest. This involves the comparison of the subject's performances on trial I and trial II with quantitative and qualitative evaluation of an improvement or deterioration. The second performance, which is particularly disturbed and deteriorated in organic cases, is especially important because it seems to give indications as to the severity and probable continuance of the anxiety state (prognosis).

Traits other than anxiety. Although the test was originally designed to give a measure of the subject's anxiety, a number of other characterological traits are projected by the individual into his performance. This is due to the fact that anxiety is not an isolated function of personality, but is related and interconnected with other behavior determinants.

Thus aggression, frequently a result of converted anxiety, is manifested by the tendency to use the distal half of the test blank, combined with constant heavy pressure and with alternating convexity and angularity of the katoptogram.

Similarly, it is generally easy to detect the impulsive individual by the extreme rapidity and headlong quality of his response.

On the other hand, feelings of insufficiency are always indicated by proximal field-distribution, high segmentation, restartings and recrossings.

The writers are now in the process of tabulating and validating as many of these linear and spatial characteristics* as lend themselves to analysis and interpretation. Some of the data will be appraised statistically; others will remain qualitative in nature; and the interpretation of a katoptogram will, like that of a Rorschach record, depend a great deal on the investigator's experience.

*This material will eventually be worked up in a monograph which the writers hope to complete in the near future.

Appraisal of all the writers' data is not yet complete, but analysis of individual records is sufficiently encouraging to justify confidence in both the method and results. The following cases are presented to illustrate the clinical possibilities of the test as well as the technique of interpretation.

Report of Cases

Case 1. *Z. T.*

This subject is an unmarried woman of 27. She draws Katoptogram I (K I) in four seconds (See Figure 2) and Katoptogram II (K II) in 19 seconds (See Figure 3). Her type of speed is SD/ST. Her responses have no lateral spread, the pressure is medium and constant, but little segmentation is observable, field distribution is

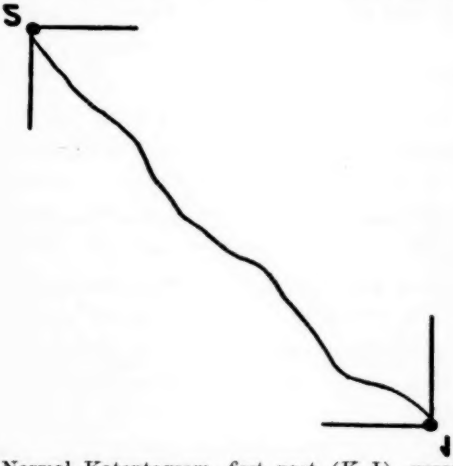

Figure 2. Normal Katoptogram, first part (K I), presenting short distance, minimal lateral spread, constant medium pressure, absence of segmentation and atactic disturbances. (Note numerals, reversed for mirror-reading.)

medial, graphomotor difficulties do not occur. Her response in the blind-drawing part of K II shows correct choice of direction and good observance of the required distances. The performance on a second trial improves in time and distance.

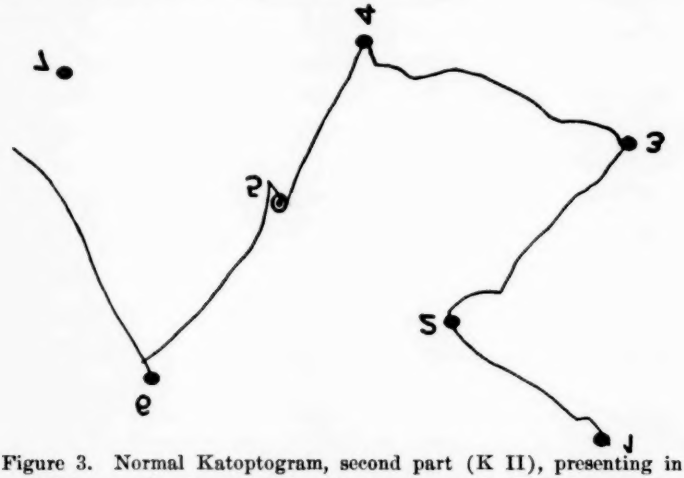

Figure 3. Normal Katoptogram, second part (K II), presenting in addition to the characteristics of performance in K I absence of disturbance due to directional changes and good, but not perfect blind-drawing responses (5-6, 6-7).

Interpretation. Absence of any disturbing anxiety tension, complete and secure self-control, mental-emotional integration and balance, integrative ability.

Comment. This young woman, although born and educated in England, left the home of her parents with their consent at the age of 18 in order to make her own way in the United States. She had no friends or relatives here, but nevertheless was able to become successful as actress and writer in a surprisingly short time. The Rorschach Test and the Minnesota Multiphasic Personality Inventory (MMPI) were administered as control tests and the records obtained show spontaneous and secure self-control, good social adjustment and self-adjustment and absence of anxiety in any form.

The performance of this subject may be considered the typical response of an emotionally stable and well-integrated individual. No disturbing basic, secondary, or situational, anxiety is likely to interfere with the self-organization, social adjustment and mental-emotional development of this personality.

Case 2. M. F.

This subject is a man of 32, married. M. F. needs 150 seconds to draw K I (See Figure 4) and 212 seconds to draw K II. A graphomotor complex at point 1 in K I indicates that the subject was apprehensive at the start and had some difficulties in getting away

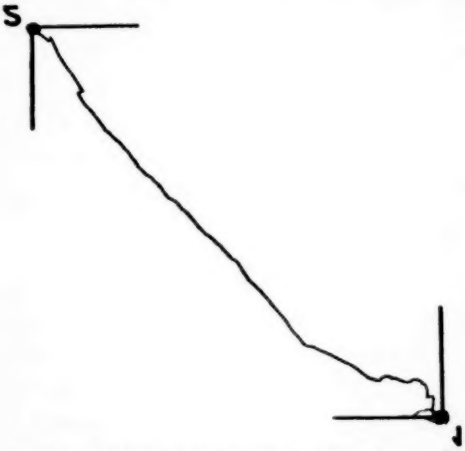

Figure 4. K I of a subject with intense basic and secondary, but well-controlled anxiety. Initial complex, SD/LT type of speed, retensive spread, heavy pressure, heavy segmentation.

from the starting point. Risking only little steps or segments, he tries to catch the right direction and once he has found it, proceeds slowly and carefully toward the goal. In K II (not shown), he goes quickly from 1 to 2, but the required change of direction at point 2 causes him so much difficulty that he develops a graphomotor block from which he can free himself only after 120 seconds. The outstanding criteria which characterize this performance are lack of spread, high time score, low distance score, high segmentation.

Interpretation. The interpretation is basic and secondary anxiety which is carefully controlled under the cover of inhibited and rigid behavior.

Comment. This subject, a Belgian, is described by five judges as "reserved, withdrawing, rigid, deliberate, suspicious, suffering from strong inferiority feelings." It may be interesting to note that this young man is only five feet tall, though of a family in

which nobody else is shorter than five feet nine, and that he has been bald-headed since the age of 19. He is extremely apprehensive, constricted, shy and evasive, and is able to keep his mental-emotional balance only by a most detailed planning of nearly every step he makes. He is rigid and overdeliberate and these and other of his traits mentioned were reaffirmed and supported by his Rorschach and TAT records, as well as by a self-description.

This case illustrates a form of anxiety in which basic and reactive elements are combined, but in which the individual is able to maintain his control, as long as only minor situational difficulties arise. The subject will therefore appear "normal" when things run smoothly, but is likely to exhibit severe anxiety in situations with which he is unable to cope.

Case 3. *R. F.*

R. F. is a woman of 26, married, born in the United States. R. F. needs 50 seconds for K I (See Figure 5) and 28 seconds for K II. She has difficulties in freeing herself from the starting point in K I, but instead of getting involved in a graphomotor block she tries to orient herself by a few impulsive and angular strokes. Unable to find her direction, she is finally forced to break up the

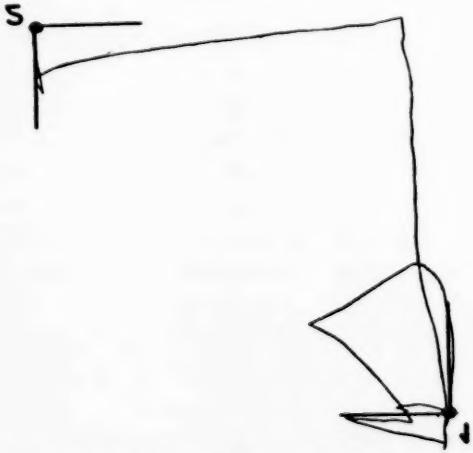

Figure 5. K I of a subject with intense anxiety, converted into aggression. Initial extensive complex, considerable segmentation, extensive unilateral spread, distal field-distribution, medium pressure, angular breaks of direction.

required diagonal into component vertical and horizontal movements. In doing so, she makes sharp angles and exercises heavy pressure. On her second trial, she follows exactly the same pattern, although requiring less time.

Interpretation. Intense basic anxiety is covered up by, and partly converted into, aggressive behavior. The predominant use of the distal field indicates that the subject feels strongly threatened by external dangers and is forced into a defensive position. Her aggression has therefore to be seen as a self-defensive measure.

Comment. This subject, like the subject in Case 2, suffers from strong organic inferiority feelings, due to an unilateral congenital dislocation of the hip. Early frustration, occasioned or aggravated by a narrow-minded, highly-egocentric mother provided the basis for feelings of inadequacy and anxiety. Her frustration has been translated into strong aggression, which causes her to fight against all sources of actual or suspected threats. Rorschach and TAT records confirm the statements of five judges personally acquainted with the subject who describe her as "extremely aggressive, self-centered and basically insecure." In an analytical self-description, R. F. sees herself as "asocial, aggressive and insecure."

This young woman illustrates a case of conversion anxiety. While the exclusive use of the distal field seems to indicate that anxiety is converted into aggression and hostility, it appears that other types of conversion anxiety can also be specifically diagnosed by the katoptographic test procedure.

Case 4. *K. K.*

Case 4 is that of an unmarried woman, aged 34. K. K. produces a graphomotor block in point 1 of K I (See Figure 6), lasting more than three minutes. This block is produced with very heavy pressure. In K II (not shown) an initial block appears, lasting 125 seconds; and there is another block at point 2, lasting more than 180 seconds. These two K II blocks are also produced with very heavy pressure; but on a second trial considerable improvement is shown.

Figure 6. KI of a subject with anxiety neurosis. Noncompletion of test within time limits, initial graphomotor block, very heavy pressure, innumerable restartings. During performance choreiform movements are observed.

Interpretation. Here is severe basic anxiety in the form of an anxiety neurosis. The heavy pressure projects the intensity with which the subject attempts a control of her anxiety.

Comment. K. K. has suffered for over a year from anxiety attacks and typically neurotic feelings of inadequacy and helplessness. Her MMPI test reveals depressive, psychoneurotic and paranoid tendencies, her Rorschach severe anxiety and depression. The subject writes in an analytical self-description: "My inferiority complex accounts for my unsuccessful, frustrated life. This is my subconscious reluctancy to get into a situation which might involve a risk, the tendency to give up even before the fight started. I am afraid that I will not be able to live up to the expectations of the people with whom I live."

This is a case of anxiety neurosis, showing as the basic symptom intense free-floating anxiety and presenting in addition obsessional elements. The threat of personality disintegration, resulting from a chronic conflict between deep-seated insufficiency feelings and environmentally stimulated ambition arouses anxiety of such an intensity that K. K. breaks down when confronted with a relatively simple, but nonhabitual task like drawing in a mirror.

The result is initial graphomotor block. At the time of her examination, the subject had started on a psychoanalysis. The marked improvement of her performance on a second trial permitted a favorable prognosis which was substantiated by the result of the subsequent treatment.

Case 5. *W. K.*

W. K. is an unmarried man of 36. He needs 140 seconds for K I (See Figure 7) and 425 seconds for K II (See Figure 8). His speed type is LD/LT; the spread is unilateral and extensive; the pressure is extremely variable; the segmentation is intense; the field-distribution in K I on the first and the second trial is distal; the linear quality is characterized by tremor and filiformity. Sev-

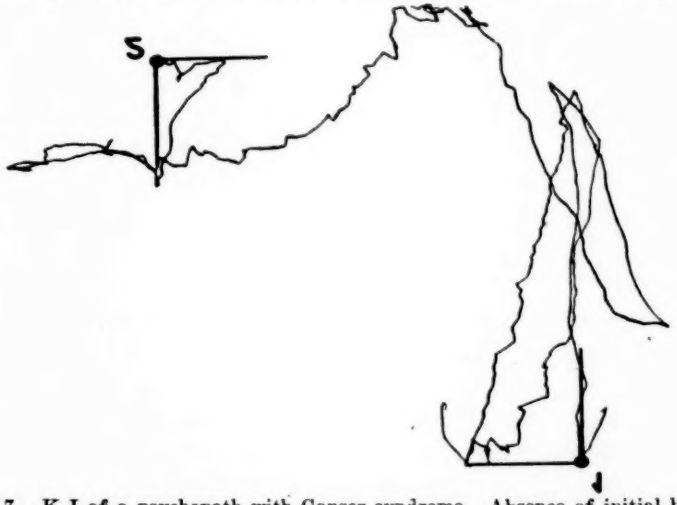

Figure 7. K I of a psychopath with Ganser syndrome. Absence of initial block or complex; unilateral extensive spread; heavy segmentation; distal field-distribution; tremor and filiformity of line retracings.

eral complexes are produced, but no blocks; several retracings are observable. On K II, the subject fails, on both trials, to follow the sequence of the numbers. His blind-drawing responses are curved, instead of the normally straight lines. Some improvement of the time and distance scores on a second trial is noticeable.

Interpretation. Here is a poorly integrated personality, with lack of self-organizing ability, psychopathic instability, basic in-

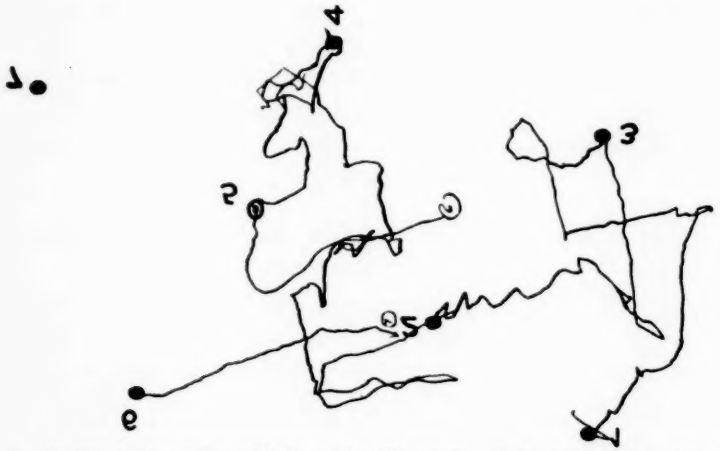

Figure 8. K II of the same subject as in Figure 7. Failure to follow sequence of numbers, curved and fragmented blind-drawing responses with wrong choice of directions, extremely variable pressure, extensive bilateral spread, heavy segmentation, disorganized progression, atactic disturbances, complexes in absence of blocks, frequent retracings.

security and anxiety with attempts at conversion into aggression. The patient manifests awareness of environmental threats. Lack of forthrightness and evasiveness are indicated.

Comment. This man was born in Austria and came to the United States at an early age. He was graduated from high school. W. K. was referred for examination by the federal court after a charge of forgery which included the use of a false name and the making of false statements. He had spent one year at a federal penitentiary for representing himself as a lieutenant in the naval reserve. His occupation prior to arrest was that of seaman. On admission to the ward, W. K. presented a classical Ganser syndrome, which continued unaltered until his return to court with a clinical diagnosis of psychopathic personality. His psychometric examination revealed average intelligence. W. K.'s Rorschach record was characterized by a large percentage of W and S responses, an unusually high percentage of Chiaroscura responses (26 per cent) and a low straight F percentage, thus showing marked anxiety combined with evasiveness.

The katoptogram of this subject is of interest because it reveals the extreme anxiety met with in certain types of psychopaths. The

manifested anxiety is neither neurotic nor psychotic in nature (as shown by the absence of initial and intermediary blocks); but consequent to intense feelings of helplessness, the subject reveals an inability to profit from experience in spite of a certain amount of insight. He is at once evasive and aggressive, and both qualities are pretty much at the conscious level*

Case 6. *F. R.*

This subject is a married man, aged 53. On the first trial, he needs 160 seconds for K I (See Figure 9) and 200 seconds for K II.

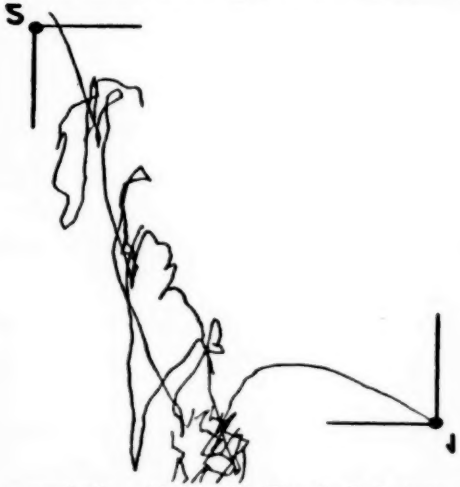

Figure 9. K I of a psychotic subject, with Korsakoff features. Absence of initial block, presence of intermediate block, LD/LT speed type, unilateral and retensive spread, recrossings and retracings, heavy segmentation, variable medium pressure, distal field-distribution, disorganized progression, atactic disturbances.

On the second trial, he takes 25 seconds for K I and 98 seconds for K II. Blind-drawing on both trials shows identically wrong choices of direction. In K I, which is primarily used for the katoptographic diagnosis, one observes an LD/LT ratio, unilateral and retensive spread, recrossings and retracings, intense segmentation, variable medium pressure, exclusive use of the proximal field,

*After being sentenced by the court, the patient's Ganser symptoms disappeared. His final psychiatric diagnosis was: psychopathic personality with pathological emotionality, hysterical features and evidence of malingering.

disorganized linear quality, intermediate block and atactic disturbances. In addition, one notices, in K II in point 4 on both trials, an intermediate block.

Interpretation. F. R. shows a progressing personality disintegration, a psychotic type of anxiety, paranoid tendencies, strong feelings of insufficiency and helplessness, unpredictable violent reactions, intense awareness of the ego as main danger zone.

Comment. This patient presents a clinical picture of progressing mental deterioration. He appears rather confused, his memory is bad. He has been unable to keep a job. There is a long standing history of alcoholism. The clinical diagnosis is: psychosis with alcoholism, Korsakoff features. The patient underwent a Wechsler-Bellevue Intelligence Test and a Rorschach Test. On the intelligence test, he made a composite I. Q. of 110 which places him at a bright normal level. There was considerable intratest and intertest variability of such a nature as to indicate organic impairment. The Rorschach record supports this picture: automatic phrases, tendency for repetitions, card description, long time needed for responses, white space interpretations, tension m's, poor form responses indicating feelings of insufficiency and anxiety.

The katoptogram of this subject is interesting because it presents manifestations of psychotic rather than neurotic anxiety. To be especially noted, is the combination of considerable graphomotor disturbances without initial block, while intermediate blocks occur repeatedly.

Summary

1. A simple and objective method and apparatus are described for the detection and the measurement of anxiety.

2. This method consists in a simplified form of mirror drawing and the consequent interpretation of the subject's motor performances.

3. The interpretation of the data is based on the disintegration concept of anxiety.

4. A number of cases are presented to illustrate the practical application of the method and its possibilities in diagnostic work.

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PSYCHIATRIC IMPLICATIONS OF INTERNAL MEDICINE*

BY HARRY A. STECKEL, M. D.

For more than 10 years, the writer has had the privilege of participating in group discussions of cases reported by students at weekly seminars, a teaching exercise introduced into the curriculum of the College of Medicine at Syracuse University in 1930.

The student is required to report, not only on the disease process for which the patient was admitted to the wards of the general hospital, but likewise to make a personal investigation of the home and the working and living conditions of the patient, giving at the same time due consideration to the hereditary, environmental, economic and social aspects of the case, with special reference of course to the part which these factors play in the etiology of the disorder bringing the patient to the hospital and in reference to subsequent treatment of the individual after his discharge therefrom. This broad and comprehensive approach to the situation tends to focus the students' attention on the patient suffering from disease rather than on the disease alone as has been likely to be the case in the past. Moreover, the student soon develops a dynamic outlook on human problems and, as a consequence thereof, he frequently uncovers emotional reactions in the patient's life situation which may be producing difficulties which are of a purely functional nature, yet are of distinct disturbance to the total economy of the individual.

Rather often the physician who is aware of home conditions is in a position so to rearrange the home setting that it will have a favorable reaction on the patient, thus avoiding much waste in medical care of chronic disorders. Unless the use of expensive procedures and clinic facilities is properly integrated with his home and working life on the basis of a clear understanding of his potentialities, physically, emotionally and intellectually, and a proper adjustment between patient and environment worked out we are apt over a period of years to waste much time and money.

Psychiatry and the psychiatric viewpoint have contributed much to a better understanding of problems of ill health which are

*Read at the interhospital conference of the New York State Department of Mental Hygiene at Syracuse Psychopathic Hospital, April 30, 1945.

closely bound up with the emotional, social and economic life of the individual, and the importance of personal relationships between the patient and his physician has been reemphasized. The present day trend toward specialization in which the right nostril is treated by Dr. Jones and the left nostril by Dr. Smith has tended to break down, or at least minimize this relationship.

As has previously been intimated, very often only a careful study of the family setting with all its complicated interpersonal relationships will give a clear picture of etiological factors producing disturbances of a functional nature which could otherwise be poorly understood, if at all, and which could never be successfully relieved without making drastic changes in the patient's environment.

Case 2 in a series of 46 seen at the University Hospital is a glaring example of this fact.

A 19-year-old girl was admitted to the hospital with the chief complaint of hiccoughing of two weeks duration, the progress unchanged. Hiccoughing occurred two or three times a minute and was resistant to all treatment. It was learned that the patient had a few months before admission complained that the children in her family, of whom there were nine younger than she, were beginning to get on her nerves. On two occasions she had fainted without apparent cause while attending the movies, and a number of times she had had dizzy spells. The physical examination at the time of her admission revealed absence of the gag reflex and an ichthyosis covering the entire body excepting the face and neck which had persisted since the age of three but which apparently did not now concern the patient. All laboratory procedures were within normal limits and the blood Wassermann reaction was negative.

It was felt therefore that the hiccoughing was functional in nature and that environmental etiological factors should be sought. A clear picture of the family situation was revealed by consulting the files of the many agencies with which the family had come in contact in the last 15 years. The family consisted of the father and 12 children, ranging from R., the oldest, who was about 21, to G., the youngest who was two. The patient was the second child. The mother had died of hemorrhage during parturition. She had

suffered much from a deformity and neuralgia of her jaw and also had been "laid up" a great deal with her many pregnancies. The father always helped about the home, doing the cooking and laundering for the family, but it was the patient who, during her father's absence, tended to the needs of the family and did the housework. The father, until her breakdown, was unable to see that the management of the 14-room house and the care of nine young children was a tremendous task for a 'teen-aged girl.

A visit to the home showed it to be meticulously clean, and it was apparent that good taste and careful planning were necessary to keep such a large house in order. The patient, who had been very fond of her mother, was much like her. She said she had done many of the household chores since the age of 14 but never had found the job difficult so long as her mother was able to supervise. Now, however, she felt very keenly the responsibilities she was obliged to assume, and the neurosis resulted. To remove this apparent etiological factor, other plans were worked out for the family, and an office position was found for the patient in which she found much happiness. A check on the patient a year later showed her well-adjusted and, although on a few occasions when very tired she has had short periods of hiccoughing, this has not been too disturbing and all members of the family are contented in their new surroundings.

It seems to the writer that this case illustrates a disorder which was a functional visceral expression of a disturbed ego; and relief was obtained only after the emotional stresses were removed.

In the series of 46 cases reviewed 11 showed broken homes—one or both parents removed—and not infrequently subsequent events often of a tragic nature could be pretty clearly traced to the faulty personality development based upon the broken home situation.

Case 29, a 39-year-old man, admitted to the hospital for peptic ulcer, it seems to the writer, illustrates this point quite well. At the age of two, he had been placed in an orphanage where he remained until he was 12. He then began wandering about the country, playing in bands and orchestras as a drummer and trumpeter. In 1928, he was in the Nicaraguan army, then at war with Honduras. From 1931 to 1934, he served a three-year enlistment in the U. S. Army in Alabama. From 1934 to 1938, he drove a truck

and played sporadic engagements with orchestras in beer gardens. He worked with a barnstorming pilot in 1939 and then had odd jobs in Binghamton, Penn Yan, Naples and finally Syracuse. He enlisted in the United States Army, December 13, 1941, but was honorably discharged November 14, 1942.

In the "Journal of the American Medical Association," Feb. 27, 1943, Bolles cites six common etiological factors in peptic ulcers of which this patient had at least three, the personality type standing out very clearly: (1) The energetic and overly-emotional character; (2) alteration in the blood supply to the stomach or duodenal mucosa due to psychogenic factors; (3) tobacco; (4) chronic infections; (5) hurried and intemperate eating; and (6) anaphylaxis.

This man, since he was 12 years of age, had never lived in one place for more than six months unless such residence was forced on him by reason of army enlistment. He apparently showed great energy when a job interested him, but his interest quickly waned. He was easily angered, his temper going up and down several times in the course of a short conversation with his wife. On the ward, he was usually agreeable, and the nurses regarded him as a model patient. The whole ward was brightened by his presence, and the other patients expressed regret when he left. He seemed at times very sensitive to the feelings of others, and he made friends very quickly and easily. He was, therefore, of the energetic and emotional character, the energy being of the nervous type, resulting more in an inability to sit quietly than in any creative urge or ambition.

This patient had used tobacco constantly from early youth and for long periods smoked two packs of cigarettes daily. As to his eating habits, it was learned that he eats so rapidly that his wife is usually only half finished with her meal when he lights his after-dinner cigarette. The type of work in which he was engaged had not been at all regular and his eating habits had, therefore, no chance to improve. Certainly factors 1, 3 and 5 suggested by Bolles are clearly present in this case.

Moreover, the present writer believes one can see how the "broken home" situation contributed to the above factors. From the start, this man was cut off from family and friends, and his life

never had the stabilizing influence of a family or a circle of intimate friends. Even his 10 years in the orphanage were broken by frequent "escapes," an evidence of distinct maladjustment and instability. In the orphanage, enough music was taught to him so that he performed acceptably well on the drums and the trumpet; and, while we ordinarily think of music as a cultural and broadening influence, in this instance his training backfired and, rather than raising his cultural level, afforded an easy way to earn a living while keeping irregular hours and getting many free drinks. His whole personality consequently grew around playing, dancing and the flowing bowl, all of which contributed to the final development of an actual organic pathology in the way of a peptic ulcer.

A comparatively large number (eight of the 46 reviewed, or 17 per cent) of the patients were classifiable as definitely mentally disordered or psychopathic, and enough were recognized and described by the inexperienced students as unstable so that instability of personality became rather a remarkable symptom in the group as a whole.

Alcoholism was much more common than would be found in any run-of-the-mine group of our adult population, 10 of the 46 cases (21 per cent) being found excessively alcoholic. Not only could personality defects leading to alcoholism be recognized, but in some cases a direct relationship of the disease processes could be traced to the chronic inebriety.

The psychopaths, although not always showing a direct connection between the psychopathy and the disease, do demonstrate the difficulty encountered in attempting to keep a thoroughly irresponsible individual under proper medical control, especially when the wife, too, is equally irresponsible.

Case 35—a man aged 68 on admission to the hospital for hypertensive cardiac disease—is an instance in point. Born in New York City in 1875, this patient was obliged to work, doing odd jobs, at the early age of nine, and consequently had no grammar school education. At 11, he ran away from home, obtaining a job as cabin boy on a merchant vessel, and spent many years at sea. Not interested or trained in any special kind of work, he had always been a wanderer. He enlisted in the navy in 1889, served

four years, and later enlisted in the army, fought in the "Boxer Rebellion" and was honorably discharged some years afterward. From this point on, the patient's story of his life is confusing and apparently not entirely reliable. He asserted at one time that he did not marry until he was 45 and that then he married a girl of only 17 and that they had four children by this union. Other sources, later confirmed by the wife's admissions, revealed the fact that the four children belonged to her but were by a former marriage. After she had obtained a divorce six years before his hospitalization, she said, she had married the patient. New York addresses of residence and employment given at various times by the patient were found to be entirely fictitious. This man and his wife were without question pathological liars. His characteristics were such that it is no wonder that, although he was hospitalized and adequately treated on three occasions, he failed to follow the physicians' instructions; and death from acute cardiac decompensation resulted within less than a year.

Not infrequently, several members of a family group are found to be definitely psychopathic so that the interpersonal relationships are of such a nature as to affect disease processes most definitely as well as to produce faulty mental attitudes in the patient.

Case 28, that of a 17-year-old girl, demonstrates this factor quite clearly. The father of this girl, although it would appear from the record of average inteiligence, was definitely paranoid in his attitude and a "ne'er do well." He never holds jobs for more than two years and regardless of financial distress has often refused jobs because they were not to his liking. The family has required much aid from welfare agencies. He spent two years in Auburn Prison for abandoning his children, at which time two indictments for second degree forgery were held against him. His last place of employment was at an army supply depot where he received a salary of $2,200 a year. After a year there, he submitted a letter to his immediate superior, stating that he did not approve of the extravagance and the haphazard way they were spending government money on transportation of supplies; and he cited many instances where money could be saved. He specifically stated that because he had four sons in the service he could not conscientiously

go on with his work unless he had an opportunity to rectify these many errors. His resignation was accepted when he submitted the letter. He declared he had reported the matter to the Federal Bureau of Investigation and stated he would be reinstated as soon as its investigation was completed.

The mother, also of average intelligence, was quite unstable, if not on the verge of a psychosis. She asserts that our patient's next younger sibling is not her own child in spite of a remarkable resemblance to the mother and the other siblings; that a shift of babies occurred at the hospital, since which time she has definitely repudiated her, to the point of on at least one occasion threatening to kill her. This child was referred to the Psychopathic Hospital for study and was taken out of the home in order to afford an opportunity to make a satisfactory adjustment.

The patient herself suffers from an intense feeling of inferiority, not alone because of the insecurity in the home situation but also because of the deformity of one leg due to a thrombophlebitis which has failed to respond to several surgical procedures. She promises to be a case for psychotherapeutic approach from time to time.

Conclusions

Only a few of the more glaring examples of the psychiatric implications and complications found in these general hospital cases have been briefly outlined.

Surely, it seems to the writer, the manner in which these cases were studied proves how exceedingly complex modern medicine is and more especially draws attention to the extreme complexity of the human beings with which it deals.

When environmental (including sociological) factors operate in harmony with the personality, health results; while, in disease, one finds harmony replaced by conflict. To understand this conflict and reduce it to harmony, is one of the huge tasks which the modern physician must accomplish.

We know that Paracelsus and Van Helmont many years ago recognized the rôle of emotional and mental factors in disease, but only in the past few decades have we assembled any real information which can be applied in a practical way.

The concept that body and mind, or, perhaps we might better say, emotions, are separate and distinct units must be scrapped. As Adolf Meyer says, it must be recognized that man functions as an integrated whole. No disease is wholly physical or wholly mental, but rather all disease is both physical and mental. Both factors must receive due consideration.

The life problems of the patient are often the key to the cause of the illness, and the efficient physician will seek for and attempt to remove these causes or, if this is impossible, help the patient to adjust to them.

Syracuse Psychopathic Hospital
Syracuse, N. Y.

PREVALENCE OF PULMONARY TUBERCULOSIS IN NEW YORK STATE INSTITUTIONS FOR THE MENTALLY ILL*

BY JULIUS KATZ, M. D., ROBERT E. PLUNKETT, M. D. AND MARY E. THOMPSON

Although isolated studies of the prevalence of pulmonary tuberculosis in a few of the institutions of the New York State Department of Mental Hygiene had revealed a high prevalence of tuberculosis,[1, 2] it was not until the recent completion of chest X-ray surveys in all the public mental institutions of the State that the total prevalence of the disease among the patients and employees was revealed.

These surveys were begun in the fall of 1941. It was expected that the surveys of all institutions could be completed in a little more than a year; but, as a result of shortages of personnel, the time necessary for the completion of the task was increased considerably.

All patients and employees were X-rayed on 4 by 5-inch films. Those individuals whose small films showed abnormal pulmonary shadows were re-X-rayed on 14 by 17-inch films, from which the final diagnoses were made. The diagnoses were based on X-ray findings only, laboratory studies being possible only to a very limited extent. Cases of tuberculosis were divided according to the X-ray diagnoses into two groups, those considered clinically significant, and those considered apparently healed (apparently cured).

As the term implies, clinically significant cases are those which are in need either of continuous treatment or of relatively frequent medical supervision. Patients in this group have tuberculous disease which is considered to be in an active or potentially active state; i. e., either the disease is roentgenologically obviously active, or else it has not yet attained maximal healing.

The cases considered to be of no clinical significance or apparently healed are, on the other hand, those which require no treatment and infrequent medical supervision. In these cases the disease has attained a state of maximal healing as judged by X-ray

*Read at the Bimonthly Conference of the New York State Department of Mental Hygiene at the Psychiatric Institute and Hospital, New York City, December, 1944.

examination. From an administrative standpoint, the cases considered as not being clinically significant are of importance chiefly because some of them, in the course of time, break down and become clinically significant.

Prevalence of Tuberculosis Among Patients

The findings among the patients and employees of the mental hospitals are considered separately from those among the patients and employees of the State schools for mental defectives and Craig Colony for Epileptics.

Mental Hospitals

In the hospitals, 73,658 patients were examined, and in 5.6 per cent of them clinically significant pulmonary tuberculosis was diagnosed. Excluding the Psychiatric Institute and the Syracuse Psychopathic Hospital, where the number of patients was very

Table 1. Prevalence of Pulmonary Tuberculosis Among Patients in New York State Mental Institutions at the Time of Initial Chest X-ray Surveys

Institution	Patients X-rayed	Cases of clinically significant pulmonary tuberculosis					Cases of apparently healed pulmonary tuberculosis	
		Total		Minimal	Moderately advanced	Far advanced		
		Number	Per cent				Number	Per cent
Mental hospitals:								
Total	73,658	4,133	5.6	2,280	1,352	501	3,964	5.4
Psychiatric Institute	85	..	..	..	..	..	..	..
Syracuse Psychopathic	46	..	..	..	..	..	..	..
Brooklyn	3,450	36	1.0	17	14	5	95	2.8
Manhattan	3,034	87	2.9	47	24	16	159	5.2
Rockland	6,864	231	3.4	134	52	45	272	4.0
St. Lawrence	2,000	76	3.8	33	29	14	239	11.9
Pilgrim	8,792	391	4.4	186	145	60	455	5.2
Creedmoor	4,662	213	4.6	146	62	5	195	4.2
Rochester	3,087	144	4.7	91	41	12	123	4.0
Gowanda	2,442	115	4.7	67	32	16	169	6.9
Utica	1,737	84	4.8	50	23	11	82	4.7
Middletown	3,314	166	5.0	88	58	20	226	6.8
Buffalo	2,451	130	5.3	109	17	4	84	3.4
Hudson River	4,977	286	5.7	85	153	48	380	7.6
Harlem Valley	4,647	301	6.5	195	81	25	296	6.4
Binghamton	2,785	188	6.8	91	55	42	174	6.2
Central Islip	7,455	599	8.0	316	212	71	496	6.7
Willard	2,950	254	8.6	142	87	25	208	7.1
Marcy	2,471	226	9.1	133	69	24	93	3.8
Kings Park	6,409	606	9.5	350	198	58	218	3.4
State schools* and Craig Colony:								
Total	15,400	377	2.4	230	105	42	268	1.7
Syracuse	966	9	0.9	4	3	2	4	0.4
Letchworth Village	4,053	57	1.4	36	13	8	32	0.8
Wassaic	4,623	79	1.7	52	16	11	104	2.2
Craig Colony	2,343	64	2.7	32	22	10	65	2.8
Rome	3,415	168	4.9	106	51	11	63	1.8

*The schools included are Letchworth Village, Rome, Syracuse and Wassaic.

small and no cases of tuberculosis were found, the prevalence of significant tuberculosis varied from 1.0 per cent in Brooklyn State Hospital to 9.5 per cent in Kings Park State Hospital (Table 1).

There is no simple, adequate explanation of this wide range in prevalence. The low prevalence in Brooklyn State Hospital may be due to the fact that this hospital acts as an admitting center and has a rapid turnover in its complement of patients. On the other hand, those hospitals which act as centers for the segregation of cases of tuberculosis found in other institutions would, of course, show a higher prevalence. In addition, such factors as age and sex distribution of patients may play an important part in determining the prevalence rates in the individual hospitals.

The relationship between age and sex and the prevalence of clinically significant tuberculosis is shown in Table 2 and in Figure 1. The rates for male patients in the hospitals rise rapidly

TABLE 2. PREVALENCE OF PULMONARY TUBERCULOSIS AMONG PATIENTS IN NEW YORK STATE MENTAL HOSPITALS AND AMONG PATIENTS IN STATE SCHOOLS* AND CRAIG COLONY AT THE TIME OF INITIAL CHEST X-RAY SURVEYS, BY AGE AND SEX

	Mental hospitals					State schools* and Craig Colony				
		Cases of clinically significant tuberculosis		Cases of apparently healed tuberculosis			Cases of clinically significant tuberculosis		Cases of apparently healed tuberculosis	
Age and sex	Patients X-rayed	Number	Per cent	Number	Per cent	Patients X-rayed	Number	Per cent	Number	Per cent
Both sexes	73,658	4,133	5.6	3,964	5.4	15,400	377	2.4	268	1.7
Males:										
All ages	34,946	2,327	6.7	1,899	5.4	8,009	167	2.1	122	1.5
Under 15 years	163	..	..	3	1.8	1,866	12	0.6	4	0.2
15-19 years	388	3	0.8	1	0.3	1,610	17	1.1	7	.0 4
20-24 years	1,125	37	3.3	9	0.8	1,131	18	1.6	4	0.4
25-34 years	4,927	286	5.8	100	2.0	1,495	34	2.3	26	1.7
35-44 years	7,223	523	7.2	309	4.3	860	31	3.6	24	2.8
45-54 years	7,118	496	7.0	417	5.9	557	26	4.7	23	4.1
55-64 years	6,722	495	7.4	464	6.9	246	14	5.7	16	6.5
65-74 years	4,014	267	6.7	329	8.2	54	6	11.1	6	11.1
75 years and over	1,772	107	6.0	147	8.3	4	..	..	..	..
Unknown	1,494	113	7.6	120	8.0	186	9	4.8	12	6.5
Females:										
All ages	38,712	1,806	4.7	2,065	5.3	7,391	210	2.8	146	2.0
Under 15 years	73	..	..	..	..	1,236	11	0.9	2	0.2
15-19 years	313	6	1.9	2	0.6	1,314	31	2.4	7	0.5
20-24 years	836	20	2.4	8	1.0	1,127	31	2.8	12	1.1
25-34 years	4,117	132	3.2	77	1.9	1,554	55	3.5	25	1.6
35-44 years	7,012	328	4.7	249	3.6	1,039	40	3.8	33	3.2
45-54 years	8,979	445	5.0	418	4.7	575	23	4.0	31	5.4
55-64 years	7,652	364	4.8	522	6.8	231	10	4.3	21	9.1
65-74 years	5,173	244	4.7	410	7.9	71	4	5.6	5	7.0
75 years and over	2,771	124	4.5	243	8.8	8	..	..	..	..
Unknown	1,786	143	8.0	136	7.6	236	5	2.1	10	4.2

*The schools included are Letchworth Village, Rome, Syracuse and Wassaic.

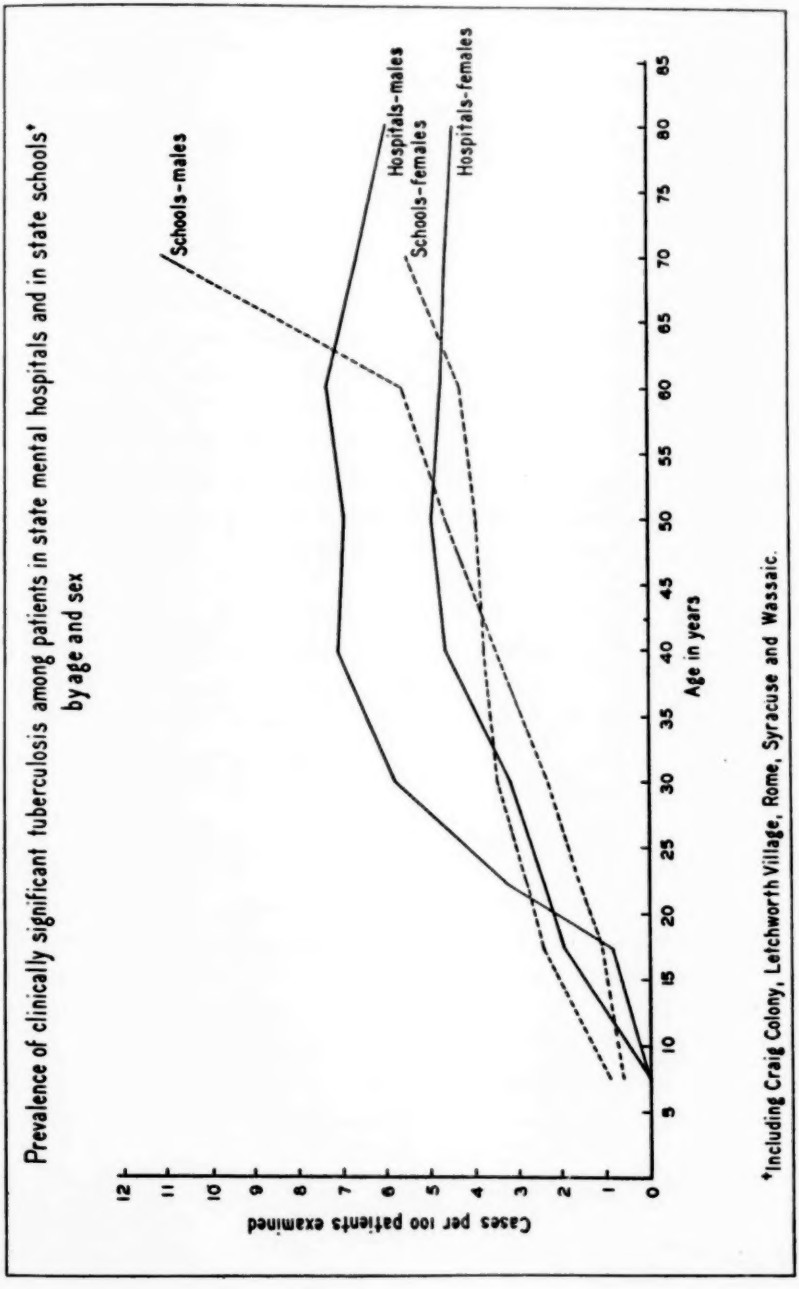
Prevalence of clinically significant tuberculosis among patients in state mental hospitals and in state schools*
by age and sex
Schools-males
Hospitals-males
Schools-females
Hospitals-females
Cases per 100 patients examined
0
1
2
3
4
5
6
7
8
9
10
11
12
5
10
15
20
25
30
35
40
45
50
55
60
65
70
75
80
85
Age in years
*Including Craig Colony, Letchworth Village, Rome, Syracuse and Wassaic.

Figure 1

from zero at ages under 15 to a peak of 7.2 per cent at 35-44 years, then remain relatively constant until the age group 65-74 is reached. Above the age of 65 there is a slight decline. Among the females, the rates rise from zero at ages under 15 to a maximum of 5.0 per cent at ages 45-54, from which there is a slight decrease in the older age groups. The rate is higher among females than among males in the 15-19 year group, but in all other age groups the rates for males are considerably higher than for females.

The prevalence of apparently healed pulmonary tuberculosis among hospital patients was 5.4 per cent, or about the same as the prevalence of clinically significant disease. There is no close correlation between the prevalence of clinically significant and of apparently healed disease in the individual hospitals. The prevalence of apparently healed tuberculosis was practically the same for males and females, being 5.4 and 5.3 per cent, respectively. The rates by age and sex are shown in Table 2.

State Schools and Craig Colony

The prevalence of clinically significant pulmonary tuberculosis among the 15,400 patients in four of the State schools for mental defectives* and in Craig Colony for Epileptics was 2.4 per cent, the rates ranging from 0.9 per cent in Syracuse State School to 4.9 per cent in Rome State School (Table 1).

Among males the prevalence increases from 0.6 per cent at ages under 15 to a maximum of 11.1 per cent in the 65-74 year age group (Table 2 and Figure 1). The high rate at ages 65-74 was in a small group and may not be significant. Among female patients, the rates also increase with age, from 0.9 per cent in the youngest group to 5.6 in the age group 65-74. The rates are higher among females than among males up to the 35-44 year group, above which the rates are higher among males.

*Newark State School is not included in this study because of the conduct at that institution of a special study of the effect of environmental factors on the development of tuberculosis. (Plunkett, R. E., Weber, G. W., Siegal, W., and Donk, R. R.: Development of tuberculosis in a controlled environment. Am. J. Pub. Health, 30:229, March, 1940. Plunkett, R. E., and Siegal, W.: Comparative study of old tuberculin and purified protein derivative. Am. Rev. Tuberc., 35:296, March, 1937.)

The total prevalence of apparently healed pulmonary tuberculosis was 1.7 per cent, the rates being 1.5 per cent among the male patients and 2.0 among the females.

Relationship Between Prevalence of Tuberculosis and Mental Diagnosis

It has long been recognized that the prevalence of tuberculosis is higher among patients with dementia præcox than among patients with other mental diseases. One of the explanations offered for this is that there may be an underlying constitutional inferiority among patients with this type of mental disease which makes them more susceptible to pulmonary tuberculosis. The effect of other factors, such as age, sex and length of time between admission and X-ray, is shown in Table 3.

Considering the prevalence of tuberculosis among all patients classified according to different types of mental disease, those with dementia præcox had the highest rate of any group in which the numbers were large enough to yield significant results. Among male patients with dementia præcox, there were 7.7 per cent with clinically significant pulmonary tuberculosis, compared with 5.2 per cent among males with all other mental conditions. The corresponding rates for females were 5.6 per cent for those with dementia præcox and 3.4 per cent for all others (Table 3).

When the prevalence of tuberculosis among all patients in relation to the length of time between first admission to a State mental hospital and the date of the X-ray is considered, it is found that the tuberculosis rates are higher for the patients with longer time periods following first admissions. More than 75 per cent of the dementia præcox patients, compared with 50 per cent of all others, fall in the group with more than five years between first admission and X-ray, where the tuberculosis rate is highest. When patients in the two groups, dementia præcox and all others, with equal periods of time following first admission are compared, the excess in prevalence of tuberculosis in dementia præcox patients is not consistently present (Table 3).

Thus, among male patients the prevalence of clinically significant disease increases with the length of time between the first admission and the initial survey X-ray film in both the dementia præ-

TABLE 3. PREVALENCE OF CLINICALLY SIGNIFICANT PULMONARY TUBERCULOSIS AMONG PATIENTS WITH DEMENTIA PRÆCOX AND AMONG PATIENTS WITH ALL OTHER MENTAL DIAGNOSES, IN INITIAL CHEST X-RAY SURVEYS OF NEW YORK STATE MENTAL HOSPITALS, ACCORDING TO AGE, SEX AND LENGTH OF TIME BETWEEN FIRST ADMISSION AND X-RAY

Age and sex	Total		Time between first admission and X-ray: Less than 6 months		6 months to 2 years		3 to 4 years		5 years and over		Unknown	
	Dementia præcox	Others	Dementia præcox	Others	Dementia præcox	Others	Dementia præcox	Others	Dementia præcox	Others	Dementia præcox	Others
Patients X-rayed												
Males—All ages	20,269	14,677	640	1,774	2,129	3,256	1,725	1,917	15,043	7,072	732	658
Under 15 years	17	146	8	32	3	83	..	20	6	10	..	1
15-44 years	10,130	3,533	532	516	1,735	775	1,347	508	6,078	1,537	438	197
45 years and over	9,258	10,368	79	1,119	349	2,308	350	1,343	8,220	5,240	260	358
Unknown	864	630	21	107	42	90	28	46	739	285	34	102
Cases of clinically significant tuberculosis												
Males—All ages	1,558	769	11	74	60	132	80	99	1,355	445	52	19
Under 15 years	..	..	..	..	..	..	..	..	..	..	..	..
15-44 years	706	143	9	15	41	25	61	12	556	86	39	5
45 years and over	765	600	1	53	16	105	17	85	718	346	13	11
Unknown	87	26	1	6	3	2	2	2	81	13	..	3
Case rates per 100 patients												
Males—All ages	7.7	5.2	1.7	4.2	2.8	4.1	4.6	5.2	9.0	6.3	7.1	2.9
Under 15 years	..	..	..	..	..	..	..	..	..	..	..	..
15-44 years	7.0	4.0	1.7	2.9	2.4	3.2	4.5	2.4	9.1	5.6	8.9	2.5
45 years and over	8.3	5.8	1.3	4.7	4.6	4.5	4.9	6.3	8.7	6.6	5.0	3.1
Unknown	10.1	4.1	4.8	5.6	7.1	2.2	7.1	4.3	11.0	4.6	..	2.9
Patients X-rayed												
Females—All ages	22,516	16,196	652	1,960	2,349	3,806	1,894	2,006	17,432	7,952	189	472
Under 15 years	11	62	5	24	4	29	1	3	1	5	..	1
15-44 years	8,596	3,682	504	548	1,646	795	1,312	490	5,048	1,686	86	163
45 years and over	12,881	11,694	110	1,274	657	2,866	537	1,431	11,479	5,939	98	184
Unknown	1,028	758	33	114	42	116	44	82	904	322	5	124
Cases of clinically significant tuberculosis												
Females—All ages	1,260	546	10	35	58	96	61	57	1,123	346	8	12
Under 15 years	..	..	..	..	..	..	..	..	..	..	..	..
15-44 years	378	108	8	7	43	20	46	11	277	67	4	3
45 years and over	778	399	2	25	15	68	14	45	743	256	4	5
Unknown	104	39	..	3	..	8	1	1	103	23	..	4
Case rates per 100 patients												
Females—All ages	5.6	3.4	1.5	1.8	2.5	2.5	3.2	2.8	6.4	4.4	4.2	2.5
Under 15 years	..	..	..	..	..	..	..	..	..	..	..	..
15-44 years	4.4	2.9	1.6	1.3	2.6	2.5	3.5	2.2	5.5	4.0	4.7	1.8
45 years and over	6.0	3.4	1.8	2.0	2.3	2.4	2.6	3.1	6.5	4.3	4.1	2.7
Unknown	10.1	5.1	..	2.6	..	6.9	2.3	1.2	11.4	7.1	..	3.2

cox and the all-other group: among the dementia præcox patients, from 1.7 per cent for those admitted within six months to 9.0 per cent for those admitted more than five years earlier, and among the patients in the other diagnostic categories, from 4.2 to 6.3 per cent for the corresponding periods. Dementia præcox patients with time periods up to five years between first admissions and X-ray show rates lower than the other patients with similar time periods, while dementia præcox patients with five years or more following admission show higher rates than the others. Among female patients the rates also increase in both diagnostic groups as the time following first admission increases. The rates among female dementia præcox patients are almost the same as the rates among other female patients in each time period up to five years. At five years and over, the rate for dementia præcox patients is higher than the rate for other patients. Further analyses are being made of the data for patients admitted more than five years before the surveys.

This relationship between the length of time since admission to a State mental institution and the prevalence of clinically significant tuberculosis, as shown in Table 3, indicates the importance of environmental factors in the development of tuberculosis among patients with all types of mental disease.

Prevalence of Tuberculosis Among Employees

Mental Hospitals

Among the 14,679 employees of the mental hospitals, 161 cases of clinically significant pulmonary tuberculosis were diagnosed, for a rate of 1.1 per cent (Table 4).

Excluding Syracuse Psychopathic Hospital, which has a small number of employees among whom no cases of significant tuberculosis were found, the prevalence varied from 0.3 per cent in Pilgrim and in Marcy, to 2.3 per cent in Harlem Valley.

The rates among employees by age and sex are shown in Table 5. The number of employees with significant tuberculosis was so small in many of the age groups that definite conclusions can hardly be drawn from these figures.

TABLE 4. PREVALENCE OF PULMONARY TUBERCULOSIS AMONG EMPLOYEES OF NEW YORK STATE MENTAL INSTITUTIONS AT THE TIME OF INITIAL CHEST X-RAY SURVEYS

Institution	Employees X-rayed	Cases of clinically significant pulmonary tuberculosis					Cases of apparently healed pulmonary tuberculosis	
		Total						
		Number	Per cent	Minimal	Moderately advanced	Far advanced	Number	Per cent
Mental hospitals								
Total	14,679	161	1.1	105	36	20	405	2.8
Syracuse Psychopathic	50	..	..	..	..	..	1	2.0
Pilgrim	1,018	3	0.3	2	..	1	43	4.2
Marcy	586	2	0.3	2	..	..	18	3.1
St. Lawrence	565	2	0.4	2	..	..	19	3.4
Brooklyn	946	5	0.5	3	2	..	27	2.9
Gowanda	489	4	0.8	3	1	..	17	3.5
Psychiatric Institute	132	1	0.8	..	..	1	2	1.5
Rockland	1,404	11	0.8	7	3	1	35	2.5
Willard	489	4	0.8	3	1	..	13	2.7
Hudson River	925	8	0.9	4	4	..	39	4.2
Kings Park	1,094	12	1.1	5	6	1	29	2.7
Manhattan	704	8	1.1	4	..	4	25	3.6
Rochester	666	7	1.1	4	3	..	13	2.0
Creedmoor	978	12	1.2	9	3	..	22	2.2
Utica	487	7	1.4	4	1	2	12	2.5
Buffalo	500	7	1.4	4	2	1	9	1.8
Binghamton	681	10	1.5	5	2	3	16	2.3
Middletown	693	12	1.7	9	..	3	28	4.0
Central Islip	1,349	25	1.9	21	2	2	15	1.1
Harlem Valley	923	21	2.3	14	6	1	22	2.4
State Schools and Craig Colony								
Total	2,768	19	0.7	8	9	2	68	2.5
Syracuse	281	1	0.4	1	..	..	6	2.1
Rome	567	2	0.4	1	1	..	16	2.8
Letchworth Village	687	4	0.6	3	..	1	14	2.0
Craig Colony	530	5	0.9	..	5	..	11	2.1
Wassaic	703	7	1.0	3	3	1	21	3.0

State Schools and Craig Colony

Only 19 cases of clinically significant pulmonary tuberculosis were diagnosed among the 2,768 employees of the four State schools and Craig Colony included in this report, for a rate of 0.7 per cent (Table 4). Just as among the employees of the hospitals, definite conclusions as to the relative frequency of tuberculosis in the various age groups cannot be drawn from the figures in Table 5 because of the small number of cases.

TABLE 5. PREVALENCE OF PULMONARY TUBERCULOSIS AMONG EMPLOYEES OF NEW YORK STATE MENTAL HOSPITALS AND AMONG EMPLOYEES OF STATE SCHOOLS* AND CRAIG COLONY AT THE TIME OF INITIAL CHEST X-RAY SURVEYS, BY AGE AND SEX

Age and sex	Mental hospitals					State schools* and Craig Colony				
		Cases of clinically significant tuberculosis		Cases of apparently healed tuberculosis			Cases of clinically significant tuberculosis		Cases of apparently healed tuberculosis	
	Employees X-rayed	Number	Per cent	Number	Per cent	Employees X-rayed	Number	Per cent	Number	Per cent
Both sexes	14,679	161	1.1	405	2.8	2,768	19	0.7	68	2.5
Males										
All ages	6,821	83	1.2	221	3.2	1,116	11	1.0	34	3.0
Under 15 years	3	..	..	..	..	..	..	..	..	..
15-19 years	200	1	0.5	..	..	17	..	..	1	5.9
20-24 years	471	5	1.1	2	0.4	57	..	..	3	5.3
25-34 years	1,582	16	1.0	25	1.6	223	3	1.3	2	0.9
35-44 years	1,882	26	1.4	60	3.2	325	3	0.9	8	2.5
45-54 years	1,386	20	1.4	62	4.5	276	2	0.7	7	2.5
55-64 years	711	8	1.1	41	5.8	175	1	0.6	11	6.3
65-74 years	134	3	2.2	11	8.2	30	2	6.7	2	6.7
75 years and over	..	..	..	..	..	..	..	..	..	..
Unknown	452	4	0.9	20	4.4	13	..	..	..	..
Females										
All ages	7,858	78	1.0	184	2.3	1,652	8	0.5	34	2.1
Under 15 years	5	..	..	..	..	..	..	..	..	..
15-19 years	436	..	..	1	0.2	34	..	..	..	..
20-24 years	1,298	6	0.5	8	0.6	200	2	1.0	..	..
25-34 years	2,207	31	1.4	33	1.5	430	2	0.5	5	1.2
35-44 years	1,919	23	1.2	65	3.4	411	3	0.7	5	1.2
45-54 years	1,228	9	0.7	45	3.7	362	..	..	15	4.1
55-64 years	396	7	1.8	21	5.3	175	1	0.6	8	4.6
65-74 years	46	..	..	5	10.9	27	..	..	1	3.7
75 years and over	2	..	..	..	..	..	..	..	..	..
Unknown	321	2	0.6	6	1.9	13	..	..	..	..

*The schools included are Letchworth Village, Rome, Syracuse and Wassaic.

RELATIONSHIP BETWEEN PREVALENCE OF PULMONARY TUBERCULOSIS AMONG PATIENTS AND ITS PREVALENCE AMONG EMPLOYEES

The relationship between the amount of clinically significant pulmonary tuberculosis among patients and the amount among employees in each institution, including State schools as well as hospitals, is shown in Table 6. There is a positive correlation between the rates for patients and the rates for employees. In other words, high rates among patients tend to be associated with high rates among employees and low rates among patients tend to be associated with low rates among employees.*

*The coefficient of correlation is +0.58, for 21 pairs of observations, excluding the Psychiatric Institute and Syracuse Psychopathic Hospital where the numbers were very small, and Willard and Marcy where the employees had been examined previously. This is definitely significant, the probability being less than .01, according to R. A. Fisher's tables, that such a correlation would occur by random sampling from an uncorrelated population. See R. A. Fisher, "Statistical Methods for Research Workers." Table V. A., p. 214. Oliver and Boyd. Edinburgh and London. 1938.

TABLE 6. COMPARISON OF THE PREVALENCE OF CLINICALLY SIGNIFICANT PULMONARY TUBERCULOSIS AMONG PATIENTS IN EACH MENTAL INSTITUTION WITH THE PREVALENCE AMONG EMPLOYEES OF THE SAME INSTITUTION, AT THE TIME OF INITIAL CHEST X-RAY SURVEYS

Institution	Patients			Employees		
	Number X-rayed	Cases of clinically significant tuberculosis		Number X-rayed	Cases of clinically significant tuberculosis	
		Number	Per cent		Number	Per cent
Mental hospitals						
Total	73,658	4,133	5.6	14,679	161	1.1
Psychiatric Institute	85	..	..	132	1	0.8
Syracuse Psychopathic	46	..	..	50	..	..
Brooklyn	3,450	36	1.0	946	5	0.5
Manhattan	3,034	87	2.9	704	8	1.1
Rockland	6,864	231	3.4	1,404	11	0.8
St. Lawrence	2,000	76	3.8	565	2	0.4
Pilgrim	8,792	391	4.4	1,018	3	0.3
Creedmoor	4,662	213	4.6	978	12	1.2
Rochester	3,087	144	4.7	666	7	1.1
Gowanda	2,442	115	4.7	489	4	0.8
Utica	1,737	84	4.8	487	7	1.4
Middletown	3,314	166	5.0	693	12	1.7
Buffalo	2,451	130	5.3	500	7	1.4
Hudson River	4,977	286	5.7	925	8	0.9
Harlem Valley	4,647	301	6.5	923	21	2.3
Binghamton	2,785	188	6.8	681	10	1.5
Central Islip	7,455	599	8.0	1,349	25	1.9
Willard	2,950	254	8.6	489	4	0.8
Marcy	2,471	226	9.1	586	2	0.3
Kings Park	6,409	606	9.5	1,094	12	1.1
State schools and Craig Colony						
Total	15,400	377	2.4	2,768	19	0.7
Syracuse	966	9	0.9	281	1	0.4
Letchworth Village	4,053	57	1.4	687	4	0.6
Wassaic	4,623	79	1.7	703	7	1.0
Craig Colony	2,343	64	2.7	530	5	0.9
Rome	3,415	168	4.9	567	2	0.4

DISCUSSION

The results of these surveys show quantitatively what has been appreciated for a long time by phthisiologists and psychiatrists, that tuberculosis is a disease of tremendous importance among patients and employees in mental institutions. The data also definitely indicate the need for an adequate, long-term control program for all the State mental institutions. An outline for such a program has already been formulated.[3] Tuberculosis being an infectious disease, the most important step in the protection of all nontuberculous patients and employees of the institutions is the segregation of the infectious cases.

Employees found in the initial surveys with pulmonary lesions requiring hospitalization were referred for treatment to the tuberculosis hospital in the community of their usual place of residence. Because of the relatively small number of such individuals requiring hospitalization and treatment, no serious difficulties were encountered in the final disposition of most of these cases.

Among the patients, the problem of segregation of cases of tuberculosis overtaxes the facilities currently available. Not only clinically significant cases diagnosed in the initial surveys, but also those found among newly-admitted or readmitted patients, all of whom are X-rayed on admission, must be segregated. Special buildings for housing tuberculous patients exclusively are available at some of the hospitals. Other institutions must provide for the segregation of tuberculous patients in separate wards of buildings also used for the nontuberculous. A few of the hospitals transfer all patients with clinically significant tuberculosis to institutions with more suitable facilities.

The present provisions for care of tuberculous patients are inadequate, and plans are under way for adequate segregation and treatment. These plans call for the transfer of all tuberculous patients to a small number of institutions which will act as tuberculosis centers. This will greatly reduce the risk of exposure of others, both patients and employees, to the hazard of infection. New buildings are to be constructed for the housing of the tuberculous patients in the tuberculosis centers, and facilities will be made available for the utilization of all the accepted modern methods in the diagnosis and treatment of pulmonary diseases.

Summary

1. Chest X-ray surveys of all the public mental institutions in New York State have been completed.

2. Clinically significant pulmonary tuberculosis was diagnosed in 5.6 per cent of the patients in the State hospitals and in 2.4 per cent of the patients in the State schools and Craig Colony.

3. The prevalence rates increase with the length of time between first admission and the X-ray survey. They also increase with age, in the hospitals up to age 45, and in the schools at all ages.

4. Among patients with time periods up to five years between first admission and X-ray, the prevalence of tuberculosis among dementia præcox patients is in general, lower than, or approximately equal to, the prevalence among patients with other types of mental disease.

5. Clinically significant pulmonary tuberculosis was diagnosed among 1.1 per cent of the employees of the State hospitals and 0.7 per cent of the employees of the State schools and Craig Colony.

6. Facilities for the segregation of patients with clinically significant pulmonary tuberculosis are inadequate at present, but plans are being made for the provision of well-equipped centers for the segregation and treatment of these patients.

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A SHORT GENETIC SURVEY OF PSYCHIC IMPOTENCE. II*

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III. Types of Penis Neurosis

The problem of the contents of specific regressions is not understandable without knowledge of analytic theory.[11] This, obviously, cannot be detailed in this survey. If, therefore, the reader is confronted with statements which seem fantastic to him, he is asked to reserve judgment until he has studied the literature more extensively. Even then his doubt will remain, since the real conviction of unconscious facts can be acquired in one situation only—in clinical psychoanalysis of the personality. This, by the way, is the reason that training of a Freudian psychoanalyst presupposes his undergoing a complete analysis, like a patient, even when the young physician justifiably maintains that he has no neurosis.

A. *Disturbances Arising from Phallic (Hysteric) Mechanisms*

The unconscious reason for the different types of hysteric penis neuroses is unsolved attachment to the mother of the Oedipal period, with subsequent repression of the sexual desire for her, identification of all sexual objects with her, persistence of castration fear, and—failure in the sex act. The fear of castration at the hands of the Oedipal father is unconsciously dynamically-effective. The whole process remains unconscious, only the "inexplicable" disturbance being visible. The disturbance may manifest itself in the following forms:

(a) Complete abstinence with camouflaged masturbation and involuntary nocturnal emissions.

*This is the second part of a two-part study of psychic impotence. The first part, dealing with "I. TERMINOLOGY AND THE FACTS BEHIND IT" and "II. 20 INFORMATIVE QUESTIONS," appeared in The Psychiatric Quarterly for July, 1945, 19:3, 402-437.

11. The description given in this chapter is a compilation of 50 years of psychoanalytic work of Freud and hundreds of his pupils all over the world. Opinions for which the present writer bears sole responsibility or those analytically not generally accepted stemming from other sources are specifically stressed, by mention of the various authors. For quotations and clinical facts on a more extensive scale, see the writer's monograph, "Psychic Impotence in Men," l. c.

(b) Complete abstinence from women, with masturbation followed by feeling of guilt and depression.

(c) Erective impotence of various degrees.

(d) The phallic form of premature ejaculation (See under "Orality").

(e) Separation of the "tender" and "sensual" components of love, resulting in impotence with women of the "respected" type and potency with those of the "degraded" type.

(f) Disturbance of potency of the "passive-feminine" type (negative Oedipus).[12]

(g) Diminished orgastic potency accompanying the disturbances mentioned in groups d, e, f.

(h) "Specific conditions" for intercourse amounting to a lessening of potency; for instance, neurotic fear of marriage, symptom complex of "detriment to the third person" (Freud), need of older woman for partner, etc., etc.

The *prognosis* of these types—as far as the symptom of potency is concerned—is favorable. The duration of treatment is approximately six months. Of course, the analysis of pathological personality traits takes much longer.

The number of possible variations of penis neuroses on the hysteric level is very great, and cannot be dealt with exhaustively here. Let us take only a few examples:

A patient entered analysis because of impotence. He said that he was afraid of female genital hair. His erections were good, but contact with the pubic hair made him "sick" and caused his erection to collapse. Analysis could prove that he really feared, not female pubic hair, but the absence of something behind and below the hair—a penis. Since the patient still unconsciously clung to the infantile idea that a woman was a castrated man, a typical fantasy of every boy, he worried about the safety of his own penis, fearing that the woman would retaliate for her own castration.

12. Under "negative" or "inverted" Oedipus is understood the feminine identification of the boy who wishes to be sexually "misused" by the father and hates his mother as a competitor. Everyone experiences in childhood both the positive and negative parts of the Oedipus complex.

Vague recollections of the story of Samson and Delilah, in which hair is used in similar symbolism, came to the fore in him. He recovered in four months.

Another patient married a woman 12 years his senior, was ashamed of the "old lady," as he called her, but was incapable of solving either his marriage or his impotence. He declared that he loved her deeply, but that sexually "it just didn't work." The simple Oedipal fixation could be resolved in a few months.

The specific condition of potency for some men is that the sexual object be a woman who is not a virgin. A man's fear of deflowering a woman may have the following unconscious causes: fear of his own aggression (for instance, fear of piercing the vagina and forming a communication between it and the anus); need to exonerate himself from the feeling of guilt (the deflorator having the "responsibility"); neurotic fear of blood (repetition of repressed infantile sadistic wishes directed toward the mother); and, also, unconscious dread of the woman's revenge (the defloration being unconsciously considered a castration, as shown by Freud). Rationalizations by means of which defloration is avoided are: greater responsibility toward a virgin, danger of making her pregnant, and danger of being forced into a marriage with her.

It is significant that men having this prohibition relate how "strangely" unfortunate they are in their choice of women; although they avoid virgins, experience having taught them that they are impotent with them, they constantly meet them. Their encounters are, of course, not accidental. They unconsciously look for a virgin as a love-object, even if she is unobtainable by them. Behind that seeking of the virgin is hidden, once more, of course, an Oedipal fantasy. The father's coitus is eliminated; the mother restored to virginal purity.

What grotesque consequences such unsolved Oedipal fixations with a consequent desire for punishment may have is shown in the following case: A businessman came to consult the writer with his younger brother, who had just been married. It seems that after the wedding night, during which he had not even touched his wife, the bridegroom had fled back to his mother and could not be prevailed upon to return to his wife. Though the marriage was financially propitious and a relief to his family, the man would not see

reason. He was deaf to threat and to logical reasoning. He asserted that he was not afraid of his wife, as his brother stated, nor was she unsympathetic to him. He alleged that he had returned to his mother because he feared for his health and wanted to consult his physician, who lived near his mother. He clung to such transparent rationalizations in spite of all his brother's scoffings. The psychoanalytic treatment desired for him by his older brother could not be arranged because the father-in-law, who was to pay the expense, preferred to give up his son-in-law.

B. *Disturbances Arising from Anal (Obsessional, Hypochondriacal, and Masochistic) Mechanisms*

1. *Obsessional neurosis.* The neurotics of the anal group regress to a level of development in which the wish to play with feces in passive surrender to the father and resultant complicated unconscious defenses against these wishes are decisive. The main disease on this level is obsessional (compulsion) neurosis. This is characterized by indecision (ambivalence), compulsions (for instance, wash-compulsion), obsessions (painful thoughts torturing the personality), magic formulae, and excessive superstition. The whole personality is imbued with constant expectation of impending doom; thoughts about death have a "front seat." The sexual ideas of these patients are tinged with anal and sadistic misunderstandings. The basic difficulty of these people can be characterized genetically as follows: The underlying aggressions are turned, because of inner feelings of guilt, inward instead of outward.[13] These patients spend their energy in warding off two wishes and corresponding super-ego reproaches: "You want to play with feces," and, "You want to be aggressive." The inner defenses are: "I am not dirty but meticulously clean," and "I am not aggressive but full of kindness and solicitude." Of course, in a roundabout way, the repressed wishes are smuggled into the defense.

Since everything "sexual" has, for the obsessional neurotic, the connotation of "dirty," his disturbance presents itself in the following forms:

13. The present writer believes that the strong aggressive tendencies of these patients are defense mechanisms against a deeper-rooted passivity. See "Two Forms of Aggression in Obsessional Neurosis," Psychoan. Rev., Vol. 29, No. 2, April, 1942.

(a) Complete abstinence masked by ascetic, esthetic, or other rationalizations, with concealed masturbation or nocturnal emissions. Patients with this symptom may refuse intercourse for idealistic or esthetic reasons. But analysis reveals that their too-strict morals have a compensatory character—fear of their own aggression, with a consequent fear of being castrated, conceived as a danger coming from the outer world. Yet they achieve complete abandonment of conscious sexual life more often than do hysteric abstainers, although they sometimes indulge in concealed masturbation (usually in the form of sadistic fantasies—"masturbation in thought") and nocturnal emissions, which often have an unconscious homosexual content. At the same time, they often make propaganda against intercourse on ascetic grounds, and despise those who are active in sexual life.[14]

(b) Abstinence with ideologic rationalizations, masturbation, and feeling of guilt. This group differs from that just described in that the practice of masturbation is conscious. The fantasies of patients in this class are unmistakably sadistic, seemingly not directly sexual. Their theme is killing, scalping, torturing of prisoners of both sexes, especially those of the male sex. At the height of the sadistic fantasy, ejaculation occurs.

(c) Erective impotence. Erective impotence is found comparatively rarely in cases of obsessional neurosis. When present, it represents an attempt to ward off unconscious fantasies of murder which are associated with the Oedipus complex and released in coitus.[15] The object of these unconscious attacks is the woman or a homosexual object, the man (unconsciously also beloved), a result of fixation on the negative (inverted) Oedipus level.

(d) Partial impotence resulting from splitting of tender and sensual components. The splitting apart of the tender and sensual components of love, as described in hysteric disturbance of potency, is fairly frequently found in obsessional neurotics, but in them it assumes more serious forms. They reject coitus with decent women as "dirty" (i. e., anal) and "beastly" (i. e., sadistic);

14. Robespierre might be mentioned as an historic instance of this type of neurotic.

15. As previously stated, these aggressions are, in the writer's opinion, defenses against a deeper passivity. See "Two forms of aggression in obsessional neurotics," l. c.

they prefer prostitutes, with whom "such things" are "allowed," although accompanied by many scruples and anxieties.

(e) Erective potency with ejaculatio retardata. Except for ascetic abstinence, erective potency with ejaculatio retardata is the disturbance of potency most frequently found among obsessional neurotics. In this form of disturbance the anal pleasure of retaining is combined with the sadistic pleasure of harming the object, arising from the notion that the woman may be hurt in some fantastic way by protracted intercourse. At the same time, ejaculatio retardata expresses the warding off of unconscious death dishes, satisfied during the ejaculation. It expresses, too, unconscious femininity and resulting unconscious rejection of women.

(f) Disturbance of orgastic potency in groups d and e. The seemingly normal function of the sexual apparatus in men having these forms of obsessional neurosis must not deceive us as to the disturbance of orgasm. Not only do obsessional neurotics fail to achieve real pleasure during coitus; their continual self-control is, as it were, the doubled sentinel which must guard against their own unconscious fantasies of aggression. But even when their coitus is attended by the most favorable circumstances, these men have disturbing thoughts—anxieties, fear of the consequences of coitus (infection, pregnancy, etc.), moralizing criticism, sometimes even obsessional formulae, etc. Their coitus is always followed by feelings of guilt, disgust, weariness, and depression. Patients of no other type will quote so frequently, "*omne animal triste post coitum.*"

2. *Chronic hypochondriac neurasthenia.* The illness has an anal genesis and the following symptom-complex:[16] Chronic constipation, meteorism, chronic head pressure, nausea, lack of appetite, impotence, usually in the form of ejaculatio ante portas, with a slack or only half-stiffened penis, spermatorrhea and dripping of urine, diffuse physical complaints, and premature mental fatigue.

16. This disease—in a modification of Freud's formulations in hypochondria—was described by W. Reich in his paper, "On chronic hypochondriac neurasthenia with sexual asthenia," Int. Z. f. Psychoan., 1926. The anal fixation of neurasthenics was described years ago by Hitschmann, a fact pointed out by Reich. Reich's results were confirmed by P. Schilder in his article, "On neurasthenia," Int. Z. f. Psychoan., 1931.

To trace all of the symptoms of this form of neurosis to their anal genesis would be very complicated and would lead too far from the subject. Suffice it to say that the main sexual disturbance characteristic of it, ejaculatio præcox, is patterned on the unconscious formula: "I will not have sexual intercourse but will make a pregenital use of my genitals." The writer will return for more details of this form of potency disturbance when he discusses oral neurotics.

Intercourse is used by chronic hypochondriac neurasthenics to prove their claim: "It is not true that I use my penis for pregenital (libidinous and aggressive, anal, urethral, scopophiliac) purposes; I am normal and actively manly." Of course, they smuggle in many of these warded-off pregenital tendencies without being aware of doing so.

3. *Beating fantasies on masochistic basis.* Freud stated in 1919:[17] "The masochistic masturbationist finds himself absolutely impotent when he at last tries intercourse with the woman. . . . A person who till that time was capable of intercourse with a masochistic fantasy, can at once make the discovery that that convenient alliance fails him, when the genital organ does not react any more to the masochistic stimulus." Such a patient suffers from *perversion masochism*—to be distinguished from psychic unconscious masochism, encountered on every level of libidinous-aggressive neurotic regression—and represents a very complicated case which cannot be understood without a survey of a complicated literature.[18]

The prognosis of potency disturbances on the anal level is less favorable than that of disturbances on the phallic one. There is a 75 per cent chance of curing these patients, the least favorable prognosis being that for perverted masochism. The duration of treatment is at least two years.

17. Ges. Schr., V, p. 365.

18. See, for instance, Freud's "A Child Is Being Beaten." Ges. Schr. V; Federn's "Contributions to the psychoanalysis of sadism and masochism," Int. Z. f. Psychoan., I and II, 1913 and 1914; Eidelberg's "Contributions to studies on masochism," Int. Z. f. Psychoan., 1934; Bergler's "Preliminary phases of the masculine beating fantasy," Psychoan. Quart., 1938.

C. *Disturbances Arising from Oral Mechanisms*

There are two types of potency disturbance on the oral level of regression: premature ejaculation and psychogenic aspermia.

All oral neurotics behave, so the writer believes,[19] unconsciously according to the "mechanism of orality." This mechanism consists of the following unconscious triad:

(a) Through their behavior they provoke unconsciously a disappointment and refusal, identifying the outer world with the "refusing," pre-Oedipal mother.

(b) Not realizing that they themselves have brought about this disappointment, they become aggressive, seemingly in self-defense.

(c) Then they indulge in self-pity, unconsciously enjoying psychic masochism.

These neurotics realize consciously only their "righteous indignation" and self-pity. They repress the fact of initial provocation, as well as that of masochistic enjoyment of self-pity.

On the oral level, the fantastic fact is clinically observable that penis and breast, vagina and mouth, sperm and milk are unconsciously identified. Here is a clinical example: A patient suffering from pseudo-mental deficiency remembered that as a child of seven he had often witnessed gypsy women nursing their children. Watching them excited him greatly sexually, and suggested to him the game of inserting a long straw into his penis, putting the other end to his lips, and drinking his own urine. In this game, he played at once the rôles of mother and suckling child, clearly identifying penis and breast, establishing an "autarchy." The patient came into analysis because of urolagnia, that is, the desire to have prostitutes urinate into his mouth.

19. There are differences of opinion in psychoanalytic literature concerning orality. Many analysts still believe that the fundamental desire of orally-regressed persons is that of "*getting,*" in direct repetition of the parasitic baby situation. A small minority—and the writer is responsible for the formulation of this minority—believe exactly the opposite, that oral neurotics want unconsciously to be *refused.* In the writer's opinion, the aggression shown by all oral neurotics is an unconscious defense mechanism against the masochistic wish to be refused.

As a result of these misconceptions of sex, oral persons have the pseudo-aggressive wish to deny (second defensive layer[20] of the "triad of orality"), since in their fantasy they were denied by the pre-Oedipal mother. Therefore, they lay greater stress on the sperm (= milk) than on anything else, underestimating the frictionary movement especially. The main symptom and sign is refusal, by means of either premature ejaculation or aspermia. In both cases fluid is denied: In premature ejaculation, the "milk" is "spilled" before it can reach the mouth (= vagina) (ejaculatio ante portas), or a few seconds after insertion, when the woman can derive no pleasure from it. In aspermia, refusal of the fluid manifests itself more directly, since these neurotics always take it for granted that it is precisely sperm which interests the woman most. The ironic twist consists of the fact that the majority of women are frigid[21] anyway, and rather enjoy protracted though spermless intercourse. Characteristic of the misconceptions of oral patients, are their reactions when it is pointed out to them in analysis that their alleged revenge on the woman is rather a blessing to her. One patient with pseudo-mental deficiency told the writer of a simple and sometimes even successful expedient he had discovered to rid himself of impotence—a "rubber." "In this way, the woman gets nothing," said he triumphantly. A condom used as punishment is a paradox which can be explained only from the oral viewpoint. Another patient consistently played off one woman against another, a typical pseudo-aggressive trick of oral people. He always had two mistresses. One day he tried to have intercourse with mistress No. 1, had an erection, used a "rubber," but found that his erection collapsed after a few movements, without ejaculation. He took off the "rubber," and deposited it in the drawer of his night table without thinking, since the girl was screaming about lack of love. The next day, he repeated the performance with mistress No. 2. He reached for a "rubber" and "by chance" got the

20. It is of great importance for the understanding of oral neurotics to take into account their use and *misuse of intercourse* for the inner alibi: "I am not masochistic and do not want to be denied; quite the contrary, I am aggressive and denying."

21. See the writer's paper, "The problem of frigidity," PSYCHIAT. QUART., 18:3, 1944, and his monograph (in collaboration with Dr. E. Hitschmann), "Frigidity in Women," Nervous and Mental Disease Monographs, No. 60, New York, 1936.

used one. "In this moment I experienced the greatest pleasure of my life. If both girls only knew. . . ."

1. *Premature ejaculation.* This is the most typical of all penis-neuroses. There are variations of it; for instance, ante portas with half-stiff or flaccid member, collapse of erection after ejaculation in a coitus lasting a few seconds, half-stiff erection not suitable for insertion, quick ejaculation on attempting to insert. The most ominous form is an ejaculation which flows like urine[22] from a flaccid penis instead of being spasmodic.

The patient's conflict arises from the fact that, being an exquisite psychic masochist (Layer 1 of the "mechanism of orality"), he is constantly reproached for his masochistic enjoyment by his "inner district attorney" (super-ego—inner, unconscious conscience), which forces the unconscious ego to furnish an "alibi." This inner "alibi" is pseudo-aggression—refusal. This "alibi," too, is rejected by the super-ego, which in turn reproaches the ego for malicious refusal. A new defense is then set up: "I don't want to refuse; I give immediately." But this precipitate "giving" is really a mockery of giving, since pleasure is refused to the woman.[23] The man with premature ejaculation behaves like someone who shows a hungry person a plate of delicious food, but throws it out of the window before the hungry one can reach for it.

Direct evidence that oral elements, often mixed with anal ones (K. Abraham), play a dynamic rôle in ejaculatio præcox is sometimes furnished by the masturbatory fantasies of these patients, and always by their dreams. One patient suffering from this disturbance had the following masturbatory fantasy during the period of puberty: He forced a small girl to eat, with great repugnance, some berries soiled with stools and urine, while he enjoyed watching her humiliation. It is characteristic of such patients, though, that they repress the knowledge of the aggression underlying their symptom. They usually object strongly to the interpretation (first given by K. Abraham) that they want to urinate upon the woman and to soil her. Indeed, almost invariably they

22. English analysts have done important work in showing the connection between urethral and oral eroticism.

23. See the writer's "Ejaculatio præcox," Psychiat. an Neurol., Bladen, Amsterdam, 1937, and the relevant chapter in his monograph on impotence.

emphasize that they are interested more in satisfying the woman and procuring orgasm for her than in their own pleasure in coitus.

The aggression of these patients refers to their oral disappointments at their mother's breasts. They transform these disappointments in a specific way by identifying themselves with the phallic mother and substituting for the normal giving in coitus a mere caricature of giving. They seek to disappoint the woman (whom they identify also with the pre-Oedipal mother) by denying the fluid, semen, just as their mother supposedly disappointed them as sucking babes by denying the fluid, milk (Rank). The patients' unconscious anxieties are of an oral nature—fear of being devoured as a reversal of their own devouring-tendencies directed toward their mothers' breasts (M. Klein). Under the pressure of feelings of guilt, they attribute their own devouring tendencies to their mothers and, in turn, other women; and they unconsciously conceive the vagina to be, not a harmless muscular tube, but a mouth which wants to devour.

On the other hand, these patients continually suffer from unconscious feelings of guilt because of their aggressive denial. To refute the accusations of their conscience, they give *at once*. Practically speaking, their immediate giving of semen is also an aggression, since, premature as it is, it deprives the female partner of her pleasure in the intercourse.

The conscious wish of patients suffering from ejaculatio præcox to satisfy their partners is rightly understood only as the result of an unconscious defense against a gigantic aggression. The unconscious wish of these patients is exactly the contrary of their conscious one. One patient having this disturbance never earned more than the absolutely necessary income, in spite of favorable circumstances, but asserted that he was sorry he could not offer his wife a home of her own, forcing her, during 15 years of married life, to live with relatives. He gained his unconscious end by means of intricate, round-about masochistic ways, literally driving well-to-do customers from his business by his provoking behavior and wasting his time with customers who paid poorly or not at all.

One can see that in his case aggression was linked with severe tendencies of self-injury. This coupling is invariable. Neurotics cannot indulge unconsciously in the luxury of hating without im-

mediately and unconsciously punishing themselves therefore. If, in a secondary phase, they sexualize their unconscious sense of guilt, they produce an especially unfavorable constellation, from which only psychoanalysis can free them.

The writer will demonstrate in the following example what a catastrophe can result to a patient suffering from ejaculatio præcox from his need to obtain oral revenge for an imagined "getting too little." A man 54 years of age entered analysis, apparently because of an "actual conflict." Although he held a very good business position, he had started a perverse liaison with the sister of a charwoman in his office, which licensed him to inspect and kiss her buttocks and masturbate. He was not restrained from so doing by knowledge of the social difference between them or of the hysteric disposition and loquacity of the woman. Unconsciously, by means of this association, he not only satisfied exhibitionistic (scopophiliac) tendencies[24] (an affair in the office!), but also apparently hoped for a scandal. When the dénouement was too slow in developing, he unconsciously tried to hasten it. On the last working-day before Christmas, he distributed in the office little presents in public, intentionally passing over the charwoman and her sister. The latter made a public fuss, and went so far as to telephone the patient's wife and tell her all of the details. His wife, 40 years of age, immediately came to his office, called him to account, and threatened to divorce him at once. A family council was hastily summoned, in which were two brothers of the wife, whom the writer had treated years ago. Through their advice, the divorce was postponed and the delinquent was sent to be analyzed "as a punishment." In analysis, the writer could discover that the patient had suffered from ejaculatio præcox from the days of his puberty, and had had no intercourse with his wife for the past 10 years, substituting for it masturbation. The analysis revealed the patient's oral fixation and fantasy of revenge. He was indignant over having to "give" by supporting his wife and 80-year-old mother, who lived with them. This indignation caused him unconsciously to wish for a situation which would prevent his support-

24. Exhibitionistic (scopophiliac) tendencies play an important part in all patients troubled with ejaculatio præcox, and are always at the disposal of the patients' *aggression*. For details see the writer's previously mentioned essays.

ing them. If, because of his liaison, he had been prematurely pensioned, seven years before he could legally claim a pension, his rather high income would have been greatly reduced, thereby forcing the two women whom he unconsciously hated to restrict their expenses considerably. In harming them, he did not mind harming himself; indeed, he wanted unconsciously to injure himself as a punishment for his aggression. As a matter of fact, in the months preceding his entry into analysis, he had used a means in addition to that of his compromising relation with the charwoman to provoke a severe conflict in his office. He had made a mistake in the very complicated work in which he was an outstanding specialist, for which his firm had had to pay damages. Had he pursued such a course at that time, when the prevailing trend was to cut down expenses, he would very likely have been pensioned before his time.

This analysis took place in pre-Hitler Austria where employees of large concerns were entitled to full pension after 35 years of service.

The neurotic attitude of another patient suffering from ejaculatio præcox may serve to illustrate how dominating is the aggression of denying as defense against underlying psychic masochism. This man had intercourse only with prostitutes of the lowest type. Asked for the cause of his strange predilection, he replied that he was incapable of spending large sums of money on women. If he happened to hear that he had paid even 20 cents more than was necessary, he became depressed. His greatest pleasure was to cheat a prostitute of money, but since such cheating led invariably to disputes, he had recourse to the following expedient: He would visit the prostitute at 10 a. m., a time at which she was idle. Since prostitutes were most superstitious in this patient's country, and would not allow their first customer to go away for fear they would earn nothing all day, he succeeded with ease in securing intercourse for a "ridiculously cheap" price. The fury of the prostitute at being underpaid was for him "the best part of the whole thing." The fact that he used his ejaculatio præcox only as a means of aggression was made especially obvious by one affair. A prostitute to whom he often went praised him one morning for the rapidity with which he had completed the act. "You are fin-

ished at once. I call that good. The others take half an hour before they are through," said she. In having intercourse with this prostitute the next time, he experienced his first normal, undisturbed intercourse.

To what an extent ejaculation serves pregenital tendencies in these patients is shown by the fact that an anamnesis of these men almost invariably reveals enuresis. This precedence of the potency disturbance by enuresis is mentioned in the first classic description of ejaculatio præcox by Abraham.[25] Abraham stresses the similarity of premature ejaculation to enuresis, pointing out that ejaculation does not follow in rhythmic ejection in these patients (with energetic, active movements of the body, maximal erection, and rhythmic contraction of the perineal muscles), but appears in a simple flowing off. The matter ejected is an ejaculation, but in mode of ejection it resembles urination. The passive method of passing semen corresponds exactly to the involuntary method of passing urine in early childhood. The genital zone has not become the leading sexual zone. The surface of the glans penis is insufficiently excitable. The sexuality of these neurotics has lost its actual male character. The specifically male genital functions, erection, emission, and frictionary motions, are lacking. An unusual erogeneity of the perineum and posterior parts of the scrotum exists.

Neurotic suffering from ejaculatio præcox may be divided, according to Abraham, into two groups. Those in the first group are lax, without energy, unmanly. Those in the second are pseudo-active, continually "on the go." The apparent contradiction between these types disappears when one considers that all activity which can achieve its end only by means of haste and precipitancy is obviously threatened by inner resistances. The restless neurotic is constantly fleeing from the unconscious resistances within him; the lax neurotic has given up the struggle. The unconscious resistances are directed against specifically manly, active behavior. As a rule, these neurotics express a marked repugnance for every sexual activity; they even feel a distinct desire to take over the *female rôle.* A patient of Abraham preferred the position of "suc-

25. Über Ejaculatio præcox. Int. Z. f. Psychoan., IV, 1916.

cubus" in having coitus. His rationalization was that, having paid a girl, he did not expect to exert himself and wanted her to "work" for the money.

Most of the pseudo-active neurotics regard coitus as a nuisance which must be finished quickly. Some of them have a certain desire for coitus and erective potency, but find that their erection disappears before emission or immediately following it.

The repugnance toward motor activity of these neurotics extends also to spheres outside of sex, for instance, sports. Many of them have a marked repugnance toward muscular exertion; while others indulge in sports with an excess of ambition and in an exaggerated, hasty manner, only to give them up completely after a failure.

But the slackness and passivity of these patients is, according to Abraham, a neurotic reaction. He finds evidence that these characteristics replace others of a too vehement, violently sadistic nature. The libido of these patients was by no means originally lacking in a sadistic component. An exact analysis will show that in the unconscious of such men there is, in addition to the unmanly-passive or hastily active disposition toward woman, another, aggressively-cruel disposition toward her, expressed, for instance, in the unconscious wish to kill her through coitus. In reaction to this instinct, they deprive their genital organ of its supposed dangerousness by slackening it and ejaculating prematurely. They retain a remnant of potency only if they are sure of the complete consent of the woman. Need for this consent accounts for their wish to receive manual help from her during the insertion.

The castration fear of these patients is expressed not only in a state of anxiety during ejaculation, but in a marked feeling of anxiety upon approach to the female genitals.

The uncommonly great self-love (narcissism) of these patients, together with their constitutionally-conditioned erotism, causes their disease to be severe. Their feeling of pleasure is localized in the urethra. Their urethral erotism causes them to overvalue the penis as an organ for the passage of urine. When, in their adult lives, they require the peculiar sexual function of the organ, they discover that it refuses to fulfill this function. "Urinating at" the woman expresses not only an infantile exhibitionistic

"proof of love" (for the infant has an exaggerated, narcissistic overestimation of his bodily products, and, when passed from one person to another, will urinate only upon the persons whom he likes), but also *contempt* for the woman. The symptom may express a belated wooing of the mother, the ejaculatio præcox being regarded as a characteristic of refined, improved manliness as opposed to the aggressive brutality of other men, but at the same time it indicates taking *revenge* upon the woman by soiling her with urine and by disappointing her expectations. It represents also a relapse into the uncontrolled voiding of early childhood.

According to Abraham, the prognosis is least favorable in those cases in which ejaculatio præcox was remarked at once in puberty and has appeared many times since during a period of several years.

Reich has pointed out[26] that there are two fundamental forms of ejaculatio præcox, which differ from each other in regard to genesis and prognosis. The following clinical variations found in the disease led the author to establish the distinction between the two forms: 1. Ejaculatio præcox may be present from the beginning of adult sexual life or may arise only after a period of comparatively strong potency. 2. The ejaculation may occur before insertion of the penis or after it. 3. The ejaculation may occur with or without rhythmic expulsions. 4. The genital organ may be stiff or it may be slack. 5. The sensitivity of the organ may lie at the glans, or it may lie in the urethra. 6. Sexual fantasies may be dominated by the conscious or unconscious idea of the penis entering the vagina, either with feeling of pleasure or that of anxiety, or they may be dominated by pregenital influences (the fantasy of nestling against the woman, kissing her breasts, being bound, etc.).

Reich divided these differences into two more or less distinct groups; ejaculation before insertion and ejaculation soon after insertion. The former is usually a urethral form of ejaculation, with a comparatively slack genital organ and pregenital fantasies. The latter is accompanied usually by erection, consists occasionally of a rhythmic flow of semen, and is always attended by active coitus fantasies. Exceptions to this grouping will occur—es-

26. Die Funktion des Orgasmus. Int. Psychoan. Verlag., p. 125 ff., 1927.

pecially that of ejaculatio ante portas with a stiffened organ. Experience has shown that the type first described is by far the more serious one and usually chronic in character, while the other type usually occurs after a period of tolerably strong potency and responds very favorably to analysis.

According to Reich, the difference between the two types may be traced to an essential difference in the structure of libido. The more serious form, ejaculatio ante portas arises from fixation at the urethral-anal stage of libido;[27] the less serious one, ejaculation soon after insertion, from fixation at the phallic stage of libido. In both, the symptom expresses, among other fantasies, that of urinating; but in the severe form urethral erotism is associated with pregenital libido, while in the less dangerous form it is associated with genital libido.

The absence of the phallic component, or the predominance of anal-urethral tendencies, in ejaculatio præcox, is evidenced by the following features: history of invariable impotence; absence of heterosexual fantasies of coitus or predominance of pregenital fantasies; inexcitability of the glans (hypoesthesia and anesthesia of the penis) and excitability of the urethra and, frequently, the entire perineal region; incompleteness or absence of erection; and passive-feminine character traits. In addition, neurasthenic symptoms, such as chronic constipation, headaches, premature fatigue, spermatorrhea, and hypochondria, are almost always present. According to Reich, the more serious form of ejaculatio præcox is a part of chronic hypochondriac neurasthenia. Phallic libido in ejaculatio præcox, on the other hand, is evidenced by these features: excitability of the glans rather than of the urethra and root of the penis; coitus fantasies; and manly personality traits—activeness, aggressiveness, sometimes even perversions as, for instance, manifest homosexuality.

2. *"Psychogenic oral aspermia."* In an article on ejaculatory disturbances[28] published a few years ago, the writer described,

27. According to the results of recent investigations, many connections exist between urethral and oral mechanisms. One of the great merits of the English school of analysis, especially of E. Jones and M. Klein, is in having pointed these out.

28. Some special varieties of ejaculatory disturbances hitherto not described. Int. J. Psychoan., XVI, 1935.

among others, two cases in which the individuals suffered from a peculiar type of disturbance of potency. He drew attention to a certain clinical picture which displays the following complex of symptoms: The patients are capable of erections but never achieve ejaculations, in spite of long-continued friction in coitus. On the other hand, they have nocturnal emissions and masturbate at times with ejaculation, which is also sometimes induced by manual friction on the part of the woman. Total absence of ejaculation is confined exclusively to coitus. In this paper, the writer described a specific clinical picture, distinct on the one hand from the familiar anal form of protracted ejaculation and, on the other, from the urethral variety of this psychogenic aspermia of which the writer has already given an account. The essential characteristic of the variety which he has isolated is that it is orally conditioned. He called this disturbance "psychogenic oral aspermia." He showed that the cause of it lay in the patient's incapacity to surmount the "breast complex," that is, it was located in the stage of pre-Oedipal fixation to the phallic mother. In their joint work on the "breast complex"[29] Eidelberg and the writer showed that, normally, children master the trauma of weaning by reproducing actively what they have experienced passively, in accordance with the unconscious repetition-compulsion postulated by Freud. From being the passive recipient of his mother's milk, the child becomes the active bestower of urine (later, semen). The purpose of this reversal is that he may free himself psychically from the trauma of weaning and preserve the infantile fiction of omnipotence, which was jeopardized. Following this line of thought about the "breast complex," the writer gave as his opinion that one of the possible results of a failure to surmount the pre-Oedipal oral mother-fixation is total absence of ejaculation. The penis refuses to perform its normal function. From motives of revenge on the woman, identified with the phallic mother, ejaculation during coitus (= milk = urine) is entirely absent. For in ejaculation the patient must do psychically precisely what he asserts the "castrating," phallic mother refused to do for him as lavishly as he wished—to cause a

29. Bergler and Eidelberg: Der Mammakomplex des Mannes. Int. Z. fur Psychoan., 1933.

fluid to flow from the breast (= penis) into the mouth (= vagina). But this pseudo-aggression is but a covering cloak for the wish to be refused by the mother.

In a continuation of this study, the writer published four further cases of oral aspermia, thus increasing his case studies to six.[30] In addition to the motif of the "breast complex," he discovered another determinant of the disturbance. It was the unconscious inhibition of the patient's own aggressive impulses, ejaculation being equated with killing, bursting the woman, and being burst himself.

In the last few years the writer has analyzed a series of cases of this type; his statistics reach the figure 14. Of all of these cases, only one has seemed to be recalcitrant, and the writer has not yet been able to decide whether this case is hopeless or simply needs more working through. Even assuming that the case is hopeless, the ratio of 13 successes to one failure is surprising, especially to the writer, since, as is evidenced in his former papers on the subject, he originally doubted whether such a deep-seated disturbance could be cured at all.

The *prognosis* of oral disturbances of potency is as follows: Psychogenic oral aspermia is curable in 90 per cent of analyses of three years duration. The results in cases of premature ejaculation depend on the type. Typical cases have a 75 per cent chance; more unfavorable, sometimes hopeless cases, however, are those in which urine-like ejaculation is combined with lack of erection during sexual excitement. The duration of treatment in cases of premature ejaculation is from two to two and one-half years. As usual, characterologic changes are more difficult to achieve than symptomatic ones. But on the oral level, symptomatic changes without personality changes are seldom recorded.

IV. Conclusions

There is in the medical profession a difference of opinion concerning potency disturbances. The majority of physicians believe that hormonal therapy is indicated and are doubtful of the psychogenesis of the disease. The minority believe that hormonal

30. Further observations on the clinical picture of psychogenic oral aspermia. Int. J. Psychoan., XVIII, 196-234, 1937.

therapy has a suggestive effect only, and then only in cases of superficial neurosis. The sexually-disturbed man suffers, according to the opinion of the latter, not from lack of libido but from a neurosis, that is, a disease of the unconscious.[31]

The present writer's personal opinion is that the great majority of cases are psychogenic in origin, but that there is no objection to using hormonal therapy as a trial. The physician should know, however, that in using hormones he is not curing the core of the disturbance, but is only availing himself of primitive and superficial psychotherapy. Should—as in 90 per cent of these cases—hormonal therapy be to no avail, he should recommend Freudian psychoanalysis.

There is not the slightest competition between the psychoanalytic psychiatrist and any other physician (general practitioner, neurologist, urologist) concerning patients with potency disturbances. The physician who sees the patient first should try or recommend hormonal therapy. If he is successful, so much the better for the patient. Nobody can, of course, blame the physician for drawing wrong conclusions from his success. Psychoanalysts believe that his success is psychotherapeutic; he claims, however, that the injections help. The practical point is that an agreement between divergent views could be reached on the following basis: Whatever illusions physicians have about hormonal therapy in cases of penis neurosis, hormones should be administered, without exception, *first*. If the patient is not helped, psychoanalysis should be recommended, as the *second* step.

Psychic impotence is an illness curable by psychoanalysis. There is not the slightest basis for regarding this illness as a natural Nemesis. When one considers the unhappiness, the frequent suicides, that could be prevented by the cure of impotence, one cannot help but wish that every doctor were aware that impotence is curable.

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31. Nobody denies that there are rare truly hormonal causes of impotence, nor that in diseases like tabes, multiple sclerosis, transverse myelitis, infantile paralysis, certain tumors of the medulla, the basis for impotence is organic in nature.

A COMPARISON OF THE WECHSLER-BELLEVUE AND THE REVISED STANFORD-BINET SCALES FOR ADULT DEFECTIVE DELINQUENTS*

BY SAMUEL B. KUTASH, Ph.D.

With the advent of the Wechsler-Bellevue Intelligence Scale and its increasing recognition as a valid, useful measure of adult intelligence, the problem of the comparability of its results with those of the new revision of the Stanford-Binet Scale has begun to occupy the attention of clinical psychologists. Halpern has compared the two scales as clinical instruments.[1] The greater suitability of the Wechsler-Bellevue material for adult subjects is now generally recognized, and clinical experience has shown that adults respond to the tests with more interest and cooperation than to the subtests of the Stanford-Binet.

Two recent studies have compared performances made on the two scales by adult mental hospital patients.[2, 3] Benton, Weider and Blauvelt[2] administered both scales to 60 patients who ranged in age from 16 to 59 years. Nineteen patients were manic-depressives, 16 dementia præcox cases, 10 involutional melancholics, five psychoneurotics, and three cases were suffering from psychosis with mental deficiency. They found a coefficient of correlation of $+.93\pm.01$ between score on the Stanford-Binet and score on the Bellevue Full Scale, $+.92\pm.01$ between score on the Stanford-Binet and score on the Bellevue Verbal Scale, and $+.73\pm.04$ between score on the Stanford-Binet and score on the Bellevue Performance Scale. These coefficients of correlation between score on the Stanford-Binet and the Bellevue Full Scale and on the Bellevue Verbal Scale are higher than that which Wechsler[4] (p. 131) found between score on the Bellevue Full Scale and score on the Stanford-Binet in a group of 14 to 16-year-old children ($+.82\pm.03$).

For patients with low I. Q.'s, Benton and his coauthors, found that the Bellevue I. Q. was consistently higher than the Binet I. Q. and for patients with high I. Q.'s, the Bellevue I. Q. was consistently lower than the Binet I. Q. However, their conclusions are based only on data for their patients with the five highest and the

*This study was completed while the author was psychologist at the Woodbourne Institution for Defective Delinquents, New York State Department of Correction.

five lowest Binet scores and thus need further verification on larger groups. The same authors also set up a table of equivalent Binet and Bellevue Full Scale I. Q. scores based upon the regression equations for predicting the Bellevue I. Q. score from the Binet I. Q. score which they found to be as follows: $Y=.63X+34$, where Y is the Bellevue I. Q. and X is the Binet I. Q. score.

It is necessary to study more intensively and on a larger group the I. Q. differences between the two scales for low I. Q. individuals and for high I. Q. subjects who are not psychotic. Benton's conclusions may only be valid for psychotic patients, and the differences at the extremes might be the result of the small number of subjects (five cases) or to psychotic deterioration which showed up more on one test than the other.

The present study seeks to compare the I. Q. scores on the two scales for 50 mental defectives who though delinquent are not psychotic and thus would not show psychotic deterioration of mentality. Also, since both the Revised Stanford-Binet and the Wechsler-Bellevue Scale are widely used for diagnosing mental deficiency and for commitment of adults to institutions for defective delinquents, it is important to discover whether their results are comparable.

Balinsky, Israel and Wechsler have studied the relative effectiveness of the two scales in diagnosing mental deficiency.[5] They defined prognostic efficiency in terms of correlation with ultimate psychiatric diagnosis and computed biserial correlations for groups of subjects ranging in number from 36 to 116. They found that the Bellevue Full Scale (verbal and performance) gave I. Q.'s which correlated highest with psychiatrists' recommendations for borderline groups. They thus concluded that the Bellevue Scale is markedly superior to the Stanford-Binet in the effectiveness of the tests as instruments in clinical diagnosis of mental deficiency. They also stressed the importance of including performance tests when attempting to differentiate between borderline intelligence and mental deficiency.

Several important questions are open for further investigation. How widely do the I. Q.'s obtained from the two scales differ for mental defectives? Have these differences, if any are found, any relation to the chronological ages of the subjects? Do the differ-

ences vary with the degree of mental defect? The present research attempts to supply answers to these questions by analyzing the results by chronological age groups as well as degree of mental deficiency. There will also be derived a set of regression equations for estimating or predicting the Binet I. Q. from the Bellevue I. Q. and vice versa for the Full, Verbal, and Performance Scales. These will be based upon the coefficients of correlation between the scales for mentally defective subjects.

Procedure and Methods of Analyzing Data

Fifty adult male inmates of an institution for mentally defective delinquents were tested with both scales. Twenty-five were tested by the Revised Stanford-Binet Scale first and the Wechsler-Bellevue Adult Intelligence Scale about one month later. The other 25 inmates received the Wechsler-Bellevue Scale first and the Revised Stanford-Binet Scale—Form L about one month later. Each subject had either been committed to the institution directly by the courts after conviction of a criminal offense and after having been adjudged a mental defective, or he had been transferred to the institution from a State prison after having been found to be mentally defective by the prison psychiatrist or psychologist. The mental conditions of some of them had been diagnosed by the use of the old 1916 revision of the Stanford-Binet, others by the use of group tests, and still others by clinical psychiatric interview. Most had been inmates of the institution at least three years.

The subjects ranged in chronological age from 16 to 59, with a mean of 35.1 years. Only inmates who were cooperative in examination and presented no serious personality maladjustments, behavior problems, psychopathy, neurosis or psychosis, were selected for testing. No inmates were included who had foreign language handicaps or presented any hearing or visual defects which would adversely influence their test performances. All were tested by the same examiner, the author of this study.

A tabulation was made, listing each subject, his chronological age, Stanford-Binet I. Q., Bellevue Full Scale I. Q., Bellevue Verbal Scale I. Q., and Bellevue Performance Scale I. Q. Differences between Stanford-Binet I. Q. and Bellevue Full Scale I. Q., Verbal Scale I. Q., and Performance Scale I. Q., respectively were calcu-

lated for each case individually, and the average differences for the group as a whole were computed. Mean I. Q.'s for the group on the Stanford-Binet, Bellevue Full Scale, Verbal Scale and Performance Scale, and the differences between the means, were determined.

The group was next subdivided into three chronological age groups as follows:

Group—15 to 30 years	15 subjects
Group—31 to 45 years	27 subjects
Group—46 to 60 years	8 subjects

The mean I. Q.'s and differences between the means were calculated for each group separately to determine the relationship between chronological age and I. Q. differences on the scales.

Tabulations were also made of percentages of cases falling into the groups 30 to 49 I. Q., 50 to 69, I. Q., 70 to 89 I. Q., and 90 to 109 I. Q., on the Stanford-Binet, Bellevue Full Scale, Verbal Scale and Performance Scale respectively. The differences between the percentages, standard error of the differences, and critical ratios of the differences were calculated to determine in which degrees of mental defect, significant differences between the two scales were present.

Finally, Pearson product-moment coefficients of correlation were computed between score on the Stanford-Binet Scale and score on the Bellevue Full Scale, Verbal Scale and Performance Scale respectively. The corresponding regression quations were calculated to provide means of estimating probable Bellevue Full Scale, Verbal Scale and Performance Scale I. Q.'s from Binet I. Q. and vice versa.

Results and Discussion

In 84 per cent of the cases the Bellevue Full Scale I. Q. exceeded the Stanford-Binet I. Q.; in 14 per cent the Binet I. Q. was higher; and in one case (2 per cent) the I. Q.'s were identical. The average I. Q. difference in favor of the Bellevue Full Scale over the Stanford-Binet was 10.92; in favor of the Bellevue Verbal Scale 12.50; and in favor of the Bellevue Performance Scale 13.78. These findings confirm those of Benton, Weider and Blauvelt, that indi-

viduals with low I. Q.'s score consistently higher on the Bellevue Scales than on the Stanford-Binet.

The differences between Binet I. Q. and Full Scale I. Q. in individual cases range from 0 to 29 I. Q. points. It is thus obvious that in certain individual cases, gross discrepancies in diagnosis of mental capacity could occur depending upon the scale used. Most of the differences over 20 I. Q. points occur in older subjects. Table 1 presents the frequency distribution of the I. Q. differences between the scales.

TABLE 1. FREQUENCY DISTRIBUTION OF I. Q. DIFFERENCES BETWEEN THE BELLEVUE FULL SCALE AND STANFORD-BINET

I. Q. points difference	Frequency
0 to 10	21
11 to 20	18
21 to 30	11

Table 2 presents the differences between the mean I. Q.'s on the scales, broken down according to chronological age groups, and for the total group.

TABLE 2. MEAN I. Q. DIFFERENCES ACCORDING TO CHRONOLOGICAL AGE GROUPS BETWEEN BELLEVUE AND STANFORD-BINET SCALES

	Differences between mean I. Q.'s		
Age group	Full scale minus Stanford	Verbal scale minus Stanford	Performance scale minus Stanford
15 to 30 years	4.67	7.54	7.21
31 to 45 years	11.59	14.96	11.86
46 to 60 years	20.38	22.33	22.45
Total group	10.92	12.50	13.78

It is evident from Table 2 that the size of the differences between I. Q. scores on the Bellevue and Stanford-Binet Scales increases with the chronological age of the subjects. This can be explained by the way in which Wechsler has provided in his norms for the normal intellectual deterioration due to chronological age. He compares each subject with his own age group while the Stanford-Binet Scale norms use a chronological age of 16 as the denominator in computing the I. Q.'s of all adults regardless of their differ-

ing chronological ages. This means that they are compared with 16-year-olds rather than with their own age group.

In Tables 3, 4 and 5, are presented the percentages of cases falling into various I. Q. groups for each of the scales, the differences between these percentages and the significance of the differences. (The following formula from Garrett "Statistics in Psychology and Education," 2nd edition, 1932, was used to compute the standard errors of the differences between percentages: $Dp = \sigma P_1 - \sigma P_2 = \sqrt{\sigma^2 P_1 + \sigma^2 P_2}$). This will indicate in what areas of mental defect significant discrepancies occur between the results on the scales.

TABLE 3. DIFFERENCES BETWEEN PERCENTAGES OF CASES FALLING IN I. Q. GROUPS ON STANFORD-BINET AND BELLEVUE FULL SCALE

I Q. group	Percentage Stanford	Percentage Full scale	Difference	St. err. of diff.	C. R.
30 to 49	20	2	18	5.99	3.01
50 to 69	68	52	16	9.67	1.65
70 to 89	10	38	28	8.07	3.47
90 to 109	2	8	6	4.32	1.39

TABLE 4. DIFFERENCES BETWEEN PERCENTAGES OF CASES FALLING IN I. Q. GROUPS ON THE STANFORD-BINET AND BELLEVUE VERBAL SCALE

I. Q. group	Percentage Stanford	Percentage Verbal scale	Difference	St. err. of diff.	C. R.
30 to 49	20	2	18	5.99	3.01
50 to 69	68	50	18	9.67	1.86
70 to 89	10	42	32	8.17	3.92
90 to 109	2	6	4	3.90	1.00

TABLE 5. DIFFERENCES BETWEEN PERCENTAGES OF CASES FALLING IN I. Q. GROUPS ON THE STANFORD-BINET AND THE BELLEVUE PERFORMANCE SCALES

I. Q. group	Percentage Stanford	Percentage Performance scale	Difference	St. err. of diff.	C. R.
30 to 49	20	4	16	6.30	2.54
50 to 69	68	38	30	9.52	3.15
70 to 89	10	48	38	8.24	4.61
90 to 109	2	10	8	4.68	1.71

The data in Table 3 show that with respect to comparative performance on the Stanford-Binet and the Bellevue Full Scale, significant differences occur in percentages of cases falling in the low grade mental defect group (I. Q. range 30 to 49) and in the borderline group (I. Q. range 70 to 89). Since it is in the borderline cases that differences of opinion concerning the diagnosis of mental deficiency often occur, the significant difference found in that group between the two scales is highly important. With respect to the comparative percentages on the Stanford-Binet and the Bellevue Verbal Scale, the significant differences occur in the same I. Q. ranges as with the Full Scale (See Table 4). But, when the percentages are compared for the Stanford-Binet and the Bellevue Performance Scale, the significant differences occur in the moron group (I. Q. range 50 to 69) and in the borderline group.

In Table 6, are presented the Pearson coefficients of correlation between the scales.

TABLE 6. COEFFICIENTS OF CORRELATION BETWEEN THE SCALES

Scales	Coefficient of correlation and probable error
Stanford-Binet L and Full Scale	.765±.04
Standford-Binet L and Verbal Scale	.733±.044
Stanford-Binet L and Performance Scale	.506±.071

It is to be noted that these coefficients, while positive and fairly high in the cases of the Verbal and the Full Scales, are .20 lower than those found by Benton and his coauthors and also slightly lower than Wechsler's finding of .82 with adolescent children. This lower correlation between the scales is of course the result of the fact that the present coefficients are based upon mentally defective subjects, and the scales present great discrepancies at this extreme.

Table 7 presents the regression equations from which can be estimated the probable score on one scale from the actual score on the other, and from which predictions can be made for mental defectives. In the equations, Y stands for Wechsler-Bellevue I. Q. and X for Stanford-Binet I. Q.

TABLE 7. REGRESSION EQUATIONS

Scales	Equations
Stanford-Binet and Full Scale	Y=.77X+24.70
	X=.718Y+8.512
Stanford-Binet and Verbal Scale	Y=.772X+29.184
	X=.696Y+6.848
Stanford-Binet and Performance Scale	Y=.582X+38.513
	X=.44Y+26.712

SUMMARY AND CONCLUSIONS

A group of 50 adult mental defectives in an institution for defective delinquents was tested with both the Wechsler-Bellevue and the Revised Stanford-Binet Scale—Form L in ABBA order. The following conclusions are justified by the test results.

1. The Wechsler-Bellevue Adult Intelligence Scale gives consistently higher I. Q. scores for mental defectives in 84 per cent of the cases.

2. The mean I. Q. difference in favor of the Bellevue Full Scale over the Stanford-Binet is 10.92 I. Q. points; in favor of the Bellevue Verbal Scale 12.50 I. Q. points; and in favor of the Bellevue Performance Scale 13.78 I. Q. points.

3. The size of the difference in I. Q. score in favor of the Bellevue over the Binet varies directly with the increase in chronological age of the subjects. A large part of the discrepancy in I. Q. results between the two scales may be attributed to the differences in norms and principles of standardization. Thus, the Bellevue Scale allows for the normal deterioration due to age whereas the Stanford-Binet does not; and, therefore, old subjects will score much higher on the Bellevue.

4. Significant differences in comparative performances on the two scales are found in the low grade mental defect group and the borderline group when the Bellevue Full Scale and Verbal Scale are involved. With respect to the Bellevue Performance Scale as compared with the Stanford-Binet, the significant differences in comparative performance are found in the moron and borderline groups.

5. A coefficient of correlation of .765±.04 is found between the Bellevue Full Scale and the Stanford-Binet, .733±.044 between the Verbal Scale and the Stanford-Binet, and .506±.071 between the Performance Scale and the Stanford-Binet.

6. Regression equations are provided for predicting probable Binet I. Q. from Bellevue Full Scale, Verbal Scale or Performance Scale I. Q.'s and vice versa.

7. On the basis of this study, it is concluded that, particularly in the borderline groups, either test alone must be supplemented by social history data and psychiatric interview in order to diagnosis mental deficiency properly. Also, other tests should be used to supplement the data.

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THE ANTICONVULSANT ACTION OF TRIDIONE*

Preliminary Report

BY FREDERICK C. THORNE, M. D.

Tridione (Abbott) is an entirely new compound with analgesic, sedative and anticonvulsant properties. The drug (3, 5, 5-trimethyloxazolidine-2, 4-dione) is a white crystalline powder with a faint balsamic odor, forming a neutral solution in water to about 5 per cent. It is chemically unrelated to either phenobarbital or diphenylhydantoin (dilantin). It is available for experimental use in capsules containing 0.33 gm. for oral use, and in 10 cc. ampules containing an aqueous solution of 1.25 gm. of tridione for parenteral use. The ampules for parenteral use may be administered by intravenous, intramuscular or deep subcutaneous injection. Preliminary studies on its analgesic effects[1] have demonstrated its toxicity in experimental animals to be very low. Animal experiments on its anticonvulsant effect[2, 3] show that tridione has a generalized anticonvulsant action in that it antagonizes chemically-induced convulsions and raises the electrical convulsive threshold.

Clinical Studies

This paper presents a preliminary report of experiments to test the anticonvulsant action of tridione in humans. The subjects consisted of a group of 11 severely deteriorated institutionalized epileptics who had been patients at the Brandon State School for mental defectives for sufficiently long periods so that each case had been thoroughly investigated from medical and psychiatric viewpoints. Each of these patients had a consistent record of regular convulsive attacks, even with medication, and were, in general, poorly controlled with phenobarbital and dilantin. The experimental group consisted of five boys and six girls with ages ranging from eight to 30 years, all of whom were idiots or imbeciles. The distribution of subjects by sex, age, clinical diagnosis and previous daily medication is given in Table 1. Four subjects were in

*The writer acknowledges his indebtedness to Dr. Louis S. Goodman for the inspiration and assistance given during his work, and to the Abbott Laboratories, North Chicago, Ill., which supplied the experimental drugs.

extremely poor physical condition at the beginning of the experiment, and two died during it of causes apparently unrelated to this study.

TABLE 1. SHOWING THE SEX, AGE, CLINICAL DIAGNOSIS AND PREVIOUS DAILY MEDICATION OF A GROUP OF DETERIORATED INSTITUTIONAL EPILEPTICS CHOSEN FOR AN EXPERIMENT TO DETERMINE THE ANTICONVULSANT ACTION OF TRIDIONE

Patient	Sex	Age	Clinical diagnosis	Previous daily medication	
H. S.	M	8	Familial mental deficiency with epilepsy	Phenobarbital	0.18 gm
T. P.	F	14	Natal-traumatic with epilepsy	Phenobarbital	0.27 gm
				Dilantin	0.27 gm
P. T.	F	14	Familial mental deficiency with epilepsy	Phenobarbital	0.12 gm
E. F.	F	30	Natal-traumatic with epilepsy	Dilantin	0.27 gm
D. L.	F	31	Natal-traumatic with epilepsy	Phenobarbital	0.27 gm
J. M.	M	14	Idiopathic epilepsy	Phenobarbital	0.09 gm
				Dilantin	0.18 gm
P. M.	F	13	Undifferentiated	None	
P. R.	F	21	Natal-traumatic with epilepsy	Phenobarbital	0.27 gm
B. L.	M	23	Idiopathic epilepsy	Phenobarbital	0.27 gm
				Dilantin	0.27 gm
A. B.	M	17	Postinfectional with epilepsy	Phenobarbital	0.12 gm
R. D.	M	11	Microcephaly with epilepsy	Phenobarbital	0.18 gm

The experimental group was studied in two control periods to compare the anticonvulsant action of tridione as compared with (A) other drugs used for previous medication, and (B) periods in which no medication was given. Control period A involved a 90-day record of the incidence of grand mal seizures with the previous medications which the subjects had been receiving. From Table 2, it will be noted that all but one patient in the group had had convulsions under previous medication during the 90-day period, with an average of 0.13 seizures per day for the whole group. In control period B, in which all previous medications were discontinued in order to determine the basic incidence of seizures for each patient, the average number of attacks increased to 0.66 seizures per day indicating that each patient was a severe epileptic. Three of the subjects went into status epilepticus within four days of the withdrawal of medication and the number of their attacks

is not included in the tabulation because of the difficulty in counting them. If the incidence of attacks in these three severe epileptics had been included, the average number of attacks in the group without medication would have been much higher. The length of control period B varied among the different subjects, since clinical judgment indicated the desirability of getting them back under medication before the predetermined period of 28 days had been completed.

The effects of tridione were studied in experimental periods ranging up to 90 days with various dosages of the drug on the patients in the group which had been standardized in control periods A and B. It will be noted from Table 2 that a daily dosage of 1.8 gms. (30 grains, given 10 grains t. i. d.) of tridione was adopted as the standard minimal dosage since preliminary trials with individual cases indicated that lesser amounts were not effective. Larger dosages of 2.7 and 3.6 gms. were given in several cases but usually made the subjects drowsy. Three patients were slightly improved with tridione over previous medication, six were essentially unchanged, and two were definitely worse than with previous medication. Nine of the 11 patients were markedly improved with tridione as compared with no medication at all, indicating that the drug does have a marked anticonvulsant action comparable to phenobarbital and dilantin.

It is unfortunate that two patients, A. B., and R. D., died during the experiment of causes which were in the writer's opinion unrelated to tridione therapy. Patient A. B. was an extremely deteriorated postencephalitic idiot who had lived on a vegetative level for several years and who was accidentally pushed downstairs by another inmate on the sixtieth day of the experiment. Four hours after striking his head against the concrete floor at the bottom of the steps, A. B. went into status epilepticus which persisted intermittently for six days despite intensive therapy with large doses of both tridione and phenobarbital. Patient R. D. was a microcephalic idiot who had never talked or walked and had spent his entire life of 11 years lying in his crib. Since 1940, he had become progressively spastic; and he began having convulsions at increasingly frequent intervals. Displaying progressive cachexia and inanition previous to his sudden death, he had shown a 50 per cent

TABLE 2. SHOWING THE AVERAGE NUMBERS OF GRAND MAL SEIZURES IN A GROUP OF DETERIORATED EPILEPTICS WITH TRIDIONE THERAPY AS COMPARED WITH CONTROL PERIODS WITH PREVIOUS MEDICATIONS AND WITH NO MEDICATION

Control period A, previous medication				Control period B, no medication			Experimental periods with tridione			
Patient	Days	Seizures	Average	Days	Seizures	Average	Days	Dosage	Seizures	Average
H. S.	90	2	.02/day	4	*	*	90	1.8 gm	2	.02/day
							3	.9 gm	6	2.0
T. P.	90	26	.28/day	14	23	1.64/day	90	3.6 gm	25	.27
							21	1.8 gm	46	2.2
P. T.	90	16	.18/day	4	*	*	90	2.7 gm	11	.12
							28	1.8 gm	7	.25
E. F.	90	7	.08/day	4	*	*	28	1.8 gm	0	.00
							1	.3 gm	1	1.00
							10	.6 gm	1	.10
							7	1.2 gm	1	.14
							28	1.8 gm	1	.03
D. L.	90	4	.04/day	28	4	.14/day	21	1.8 gm	7	.33
J. M.	90	0	.00/day	15	45	3.00/day	90	1.8 gm	2	.02
P. M.	No medication given			90	19	.21/day	90	1.8 gm	22	.24
P. R.	90	16	.17/day	28	6	.21/day	90	1.8 gm	47	.50
B. L.	90	18	.20/day	28	8	.29/day	90	1.8 gm	19	.20
A. B.	90	13	.14/day	28	11	.39/day	60	1.8 gm	4	.06
							6	3.6 gm	11†	2.00†
R. D.	90	32	.35/day	25	10	.40/day	63	1.8 gm	13**	.20**

Key: *Status epilepticus, continuous seizures.
†Died in status epilepticus after fall.
**Died suddenly of inanition.

decrease in seizures during the period when he was taking tridione.

Major toxic reactions from tridione were not encountered although one patient, E. F., developed a severe systemic reaction involving massive facial edema, stomatitis and a maculo-papular-vesicular dermatitis on the twenty-eighth day of tridione therapy. The drug was immediately discontinued, even though not directly implicated, since conjunctival and skin tests were negative, as were hematological studies. Two weeks after the dermatitis and systemic reactions had completely disappeared, this patient was again started on tridione beginning with 0.3 gms. and working back slowly to the maintenance dosage of 1.8 gms. daily without further complications. The consulting physician at the institution considered this patient's acute reaction to be allergic in nature and unconnected with tridione therapy. This conclusion seems supported by the failure of recurrence when the drug was readministered and by the failure to obtain positive conjunctival or skin tests.

The anticonvulsant action of tridione appears to be proportional to the dosage administered, different patients showing various thresholds of effective suppression of seizures. Seizures were not effectively controlled with average daily dosages less than 1.8 gms. in this group and drowsiness was encountered with daily dosages over 3.6 gms. This hypnotic action is desirable in deteriorated epileptics who are noisy and overactive. Patients D. L. and P. R., who were unimproved with tridione, were natal-traumatic idiots with definite organic lesions.

One of the disadvantages of tridione in its present capsular dosage form is that some patients, notably intelligent outpatients, resisted the idea of having to take six or more large capsules daily.

The parenteral method of administration is very effective in terminating status epilepticus quickly and without unpleasant reactions. To date the writer has treated six cases of status epilepticus with parenteral ampules containing 1.0 gm. of tridione given both subcutaneously and intravenously. In two cases, 1.0 gm. of tridione subcutaneously resulted in a complete cessation of convulsive movements in from 10 to 15 minutes, following which the patient slept quietly for several hours. Four patients in status epilepticus have been given 1.0 gm. intravenously with cessation of convulsive movements within 15-30 seconds after the injection

was terminated. The injections were well tolerated and controlled convulsions for several hours until other forms of medication could bring the patient back under control.

Summary

Tridione (3, 5, 5-trimethyloxazolidine-2, 4-dione) is a new compound showing marked anticonvulsant and slight sedative action in humans. A preliminary report is made concerning the effectiveness of tridione as compared with phenobarbital and dilantin. In a group of 11 mentally defective institutionalized epileptics, three were better controlled by tridione than with previous medications, six were essentially unchanged, and two had more seizures with tridione than with phenobarbital and dilantin. Nine of the 11 subjects showed a strong anticonvulsant action with tridione, which appears to be as effective as phenobarbital or dilantin in antagonizing convulsions. No major toxic effects were noted, although two patients died of extraneous causes during the experiment. The sedative action of tridione in large dosages is effective in decreasing the noisy overactivity of deteriorated epileptics. It is concluded that tridione is a strong anticonvulsant drug which deserves further intensive investigation.

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FURTHER OBSERVATIONS ON HALLUCINATIONS OF SMELL

BY G. M. DAVIDSON, M. D.

I

In 1938, the present writer reported in the pages of this QUARTERLY the results of a study on hallucinations of smell. The study concerned a number of patients of both sexes, of the age group of 20 to 65, representing various nationals, and belonging to various groups of psychiatric classification. The problem was investigated, as far as possible, from the standpoint of relationship, meaning the relation of a part (the olfactory system) to other parts (other parts of the personality system) and subordination of all parts to the whole (the total personality). The biological, psychological, physiological, neurological and chemical aspects of the problem were discussed. The following conclusions were reached.

Hallucinations of smell may be present in any mental disorder.

There is no apparent selectivity by sex or group of national origin.

The hallucination may occur at any age, but the majority of cases fall in the involutional period of life.

All cases smelled uniformly "bad" odors.

No matter what the diagnosis in the case was, there was a distinct involutional coloring to the clinical picture.

Hypogonadism was found to be a common underlying constitutional factor. If not originally present, the factor could be, in some instances, the result of various affective or somatic experiences, as shown in the present writer's work on psychoses related to pregnancy and childbirth.

There were two forms of hallucinations of smell: The one is referable to the person himself (I smell bad) and is akin to self-accusation; the other is projected (I am blamed by others for smelling bad; fumes are caused by others), and is a form of indirect self-accusation.

The hallucinations of smell were interpreted further as symbols of danger, as forms of defense, or rejection of an unacceptable sit-

uation. Sometimes the hallucinations could be understood as punishment for guilt. The hallucinations in question were indicative of sexual crisis.

In a subsequent study on "involution," hallucinations of smell are found at times to be conspicuous to such an extent that the writer suggested they be regarded as a symptom of the "involutional mental syndrome." Olfactory hallucinations were also found in certain cases of acute alcoholic hallucinosis. Here again, the hallucinations occurred chiefly in the involutional period. Therefore, it was suggested that we are dealing in such cases with involutional episodes precipitated by alcohol.

As already noted, most of the cases with hallucinations of smell have shown an involutional coloring to the clinical pictures. The question arose as to how the situation could be explained in younger persons. A comparative study has shown that from a broad psychiatric viewpoint, there was no essential difference between involutional melancholia of middle age and agitated depression of earlier life, or the same condition of advanced age. The difference in expression of external manifestations in the conditions mentioned was believed due to: (1) the degree of expression of physiological changes which are more pronounced at middle age; (2) the difference in workings of the system of defense of the personality at different ages; and (3) the difference of life experiences and of psychology of each period of life. This formulation allowed for both physiological and psychological exacerbations. For details, the writer would refer to those studies.

Since the hallucinations of smell were indicative of sexual crisis and since the cases studied were related to significant epochs of life, particularly involution, the question of puberty remained still open. The present writer has been fortunate in having observed recently two patients manifesting hallucinations of smell at puberty. They are reported here. This report is, therefore, warranted and completes the original investigation.

II

The following are the cases:

Case 1. W. H. This is the case of a girl of 12. Her father is alcoholic, unstable, at times separated from his family; the mother

is believed to be paranoid. The patient was born in the United States, the older of two girls. The history of her early development is unknown. She was brought up by her parents until the age of six, at which time she was left with her grandmother, as the parents moved to another city. One year previous to her present difficulty, the patient joined her parents again. The mother was overreligious and took her to church about three times daily. Her school record was reported as good. She played well with other children, was helpful in the house, and was described otherwise as normally cheerful. Menstruation was expected but had not taken place. Diseases, injuries and toxic influences were denied.

One month prior to admission to the hospital, the patient was approached sexually by a boy. She refused him, and the boy hit her over the head with his fist. Since then, she appeared at times to be absent-minded and preoccupied. Later, she was observed to be attracted by any red object. Still later, she was observed "to be conversing with angels." She was afraid to stay by herself, and was hospitalized.

In the hospital, W. H. was found to be in good physical condition. Her height was five feet, her weight 86 pounds; she showed a maturing girl's body, with fairly well-developed secondary sex characteristics. Heart, lungs and abdomen were negative for physical disorder, blood pressure was 110/80. The girl was uncooperative for gynecological examination. Her blood Wassermann was strongly positive, her spinal fluid entirely negative, her urine negative. Neurologically, her examination was negative.

Mentally, it was noted that she was excited, showing catatonic states on and off with mutism and refusal of food. When accessible, her sensorium proved clear. The psychometric test gave her an I. Q. of 80, and she was considered dull normal. During excitement, she was spontaneous, talked exclusively on sexual topics, and used rather obscene language. She spoke of sexual play with boys which she now resented. She complained that the devil was using her continuously sexually, the doctors did the same to her at night. She thought that she was going "crazy," due to the continuous sexual abuse she was undergoing, but that she could not stop it. She spoke of her father kissing her "hard," putting his tongue into her mouth. She identified herself with her mother and

rejected her. She pretended to be married. This incessant stereotyped obscene talk continued for several days.

On one occasion, W. H. complained of smelling smoke and thought there was a fire. At that time, she "heard and saw the Virgin Mary." On another occasion, she complained that the nurses poisoned her food which tasted and smelled bad. When she began to improve, she expressed a desire to be good and to go to Sunday school.

Case 2. J. B. This patient was a boy of 13. His father was alcoholic and unstable, his mother mentally deficient; one half-brother was delinquent. The patient was born in the United States. the second of six siblings by his mother. He was "sickly" as a child, was his mother's "best boy," affectionate and helpful. His school record was poor; he was mentally deficient; other boys made fun of him, for which reason he was taken out of school by his mother. When a small child, he had occasional convulsions; later they stopped, but had recently recurred. He would have them about twice a month. No other diseases, injuries or toxic influences were known.

His present difficulty was accounted for as follows. The patient had been sharing his bed with an older brother. The latter attempted sexual intercourse with him, following which the patient became rather quiet and would not go out. When sent to the park, he would have difficulties there with other children. For several days prior to admission to the hospital, the boy was complaining of smelling gas in the apartment, even though his mother would try to show him that the gas jets were closed.

In the hospital, he was found to be in good physical condition. Examinations, inclusive of laboratory tests were negative. Mentally, he was quiet, childish, occasionally mischievous. He admitted his difficulties at home but denied any trouble in the hospital. He was not disoriented. The psychometric test gave him an I. Q. of 60. He had occasional petit mal attacks.

Unfortunately our informants in the cases were neither very intelligent, nor willing to give detailed information about the patients. However, the foregoing account illustrates sufficiently the presence of hallucinations of smell at the time of puberty. The

conflict is self-evident even from the brief outlines. The experience and expression are about the same as in the other reported cases of different age groups.

III

Since the time of the writer's original report on hallucinations of smell, further investigation and observation has confirmed the conclusions and interpretations reached on the subject, as briefly outlined in the first part of this report.

Hallucinations of smell of "bad" odors as observed in our cases are definitely related to sexuality. As to the evolution of the clinical manifestation, one observes first a state of sexual crisis which may be precipitated by physiological or psychological factors, or both. During such a crisis, sexual desires are particularly unacceptable. Paradoxically as it may seem, there is at the time of crisis an increase in, or flare-up of libido which compounds the conflict. The person develops ideas of guilt which are later followed by the hallucinations of smell.

Considering the relationship of cranial nerves to reproductive organs (for details see the writer's original paper), the hallucinations of smell whether of the variety described, or occurring in the course of brain tumor, or epilepsy ("uncinate fits"), etc., or in dreams are indicative on the physiological level of acute gonadal insufficiency. Other symptoms of the latter condition may be easily ascertained once one is looking for them.

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INSTITUTIONALIZING THE OBSESSIVE PSYCHOPATH

BY WLADIMIR ELIASBERG, M. D.

Fifty years ago, in Germany and in Switzerland, there appeared two books, one by J. L. Koch, the other by Anton Delbruck, on "Psychopathic Inferiority" and on "Psychopathic Lying and the Mentally Abnormal Swindlers." These were the first monographs on a type of psychopathy which is exceptionally troublesome socially. Fifty years ago! In the July, 1944, issue of "The Journal of Clinical Psychopathology," Hervey Cleckley writes about "The Psychosis that Psychiatry Refuses to Face." The paper was read at the Round Table Conference on the Psychopathic Personality at the Centenary Meeting of the American Psychiatric Association in May, 1944, at Philadelphia. Cleckley, referring to about the same type of personalities as were described by Koch and by Delbruck, wants psychiatry to recognize that these psychopaths are psychotics. More important than the classification, is the question as to whether we have made some headway in the treatment of these people.

Again, a historical reminiscence. There was a time when the physiology of hysteria and the hysterical *arc de cercle* were demonstrated and described by J. M. Charcot. One knows today that there is no such typical sequence of stages in the hysterical fit. Moreover, the classical hysterical fits have become rarities since those 10 specimens preserved in the Charcot service, have died away. There have been more "psychiatrogenic" artifacts on the ledgers of mental disorder. And it might be useful to remember that certain neighboring "ists," psychologists, for instance, have seen fit to point their fingers at what they call psychiatric malpractice (Link, in July, 1944, issue of "American Mercury"). Those attacks have been duly refuted by leading psychiatrists, among them C. Charles Burlingame, but *aliquid semper haeret.* And if this sting lasts, it may even be good.

Here is a case from practice. A 27-year-old white woman, the oldest daughter, has always been very much spoiled by an oversolicitous mother. As a child, she felt hurt when her two and one-half years younger sister was born. She was sexually curious at the age of eight years. School marks were good. She worked at

clerical jobs. At the age of 17, she was engaged to a man in many respects her inferior. She married him after several somewhat ominous procedural failures (*Fehlleistung*): Three times, when applying for a license, she forgot her birth certificate. The marriage was a failure from the beginning. The husband could do nothing to satisfy her in any way. If he was nice, she thought he was a weakling. There was never any sexual gratification on her part.

She became entirely intractable, and was sent to a mental hospital for four weeks. When she came back, she carried on in the same way. She was then transferred to the Psychiatric Institute, where she was diagnosd as a hysterical personality, very demonstrative, with good intelligence. She received 10 electric shocks to no avail. She was then cared for in a clinic, and later in several offices of private doctors, who could all—more or less—get along with her. During these years, she went out playing cards, kept up her social contacts, and "let loose" only in the family. While she declared that she hated her mother, could not stand her flabby body and mind, she was, at the same time, very nice to her. She did everything she possibly could; spent what little money she got from her husband on gifts for her mother, sister, and brother. She bought gifts for them, while she herself did without the necessities.

She has carried on in this way for four years. The husband left, at the suggestion of a doctor, two years ago. For two years, the patient has been repeating the following act absolutely stereotypically. She comes in with a sarcastic smile, states that never in her life has she been so ill as today. She cries, asks to be examined, because something must be the matter with her, preferably brain tumor, meningitis, cancer, or chest disease, "I want to be examined." Woe unto the doctor if he asks anything. "So you don't know? You should have known that all along." She brings out obsessive-compulsive ideas: She must kill her mother; she must kill everybody, particularly everybody in her family. Her father, she must kill because he coughs; her sister-in-law, because she is not good to her brother; her sister doesn't know how to handle her husband; her brother, she could kill because he doesn't believe in her illness; some women, she must hit over their breasts; and herself, she must kill because she cannot go on in this way. She is terrified because the first idea when she sees a small child is that

she must hit his head against a wall. "But these are not the things. The thing is . . ." and she describes changes in the autosomatic sensations. There is only half of her body alive.

She never wants to leave the office. She must be seen six, or even seven times a week. At the end, she usually takes scraps of paper from her pocketbook, written in a way that is reminiscent of a schizophrenic disorder. She reads, or rather comments, about them, wants the doctor to read them most carefully. "But again, these are not the things. The thing is . . ." and she again starts with any of the matters mentioned in the foregoing.

An arrangement was made that she should work, otherwise she would not be allowed to come to the doctor's office; and lo and behold, she worked for one and one-half years. She made $24 and even $30 dollars a week; and the family was happy, if not about anything else, then at least about this. As remarked, this went on stereotypically, but the patient worked. When the writer could not continue her treatment because of other urgent work, there was a collapse. The writer suggested insulin treatments, more as a makeshift, than because of his firm belief. The result was as anticipated; the collapse became complete.

This patient has been transferred to a hospital, where the magic circle or spiral continues. She is again examined. Those strange feelings are again noted. Endocrinology is brought to bear on the case.

Away back in 1892, Koch stressed reeducation, self-control, denial, strengthening of the general morale, understanding of one's duties, etc. Today, we would call that psychagogy or strengthening of the super-ego—and we should be able to understand the genesis of the weakness of the super-ego better than on the basis of the so-called degeneration theories (Morel and his followers). So far, so good. How about the aspect of therapy in practice? One thing direly needed is a psychopaths' and neurotics' record, kept in a central file, and made accessible to all physicians; this file would be comparable to the records kept on criminals. The examination of patients who already have records, should be cut short. What we see today are repetitions of the whole costly, cumbersome, and harmful procedure in every hospital, sanatorium, clinic, or office these patients choose to enter. Not among the least

of the objections to this, is the harm done to the patient himself. One might recall the hysterics who have succeeded in getting the surgeons to operate on their abdomens repeatedly. Just recently, Carl R. Rogers has laid emphasis on the fact that the situation of examination is not beneficial if counseling is intended. And we psychiatrists may add: It is not good for transference.

Again, arrangements should be made so that these patients should earn, at least what they will need for treatment; they should keep up their social contacts, and the neurosis should be limited to the private sphere, preferably to the office of the physician. In other words, it is an achievement if the patient can carry on in the form of the "indoor or office neurosis," which indeed can be achieved with many compulsive-obsessives.

Who will pay? Many of these patients will not be able to compensate the physician for the time and trouble they cause him. It is, of course, doubtful whether such cases could be taken care of by voluntary or compulsory sickness funds. As, however, these patients will be able to earn, this sort of payment might be feasible, at least in part. The criminal psychopaths, the anethopaths (B. Karpman) and that type described by Cleckley, are, fortunately, only a small part of the group. More difficulties may arise in the differential diagnosis of the obsessive-compulsive psychopath and the typical paranoiac—not the paranoid schizophrenic. Paranoiacs may commit the most dangerous crimes—murder, mass murder. Only the experienced psychiatrist can make a reliable diagnosis. As a rule of the thumb, one might say that the more there are compulsive and obsessive symptoms, the less these patients will enter the field of actual criminality.

The treatment will consist—reversing the usual sequence—in a psychagogic part first, to make the patient accessible to psychoanalysis. In the first part, every technique may be used that would be calming, pharmacologically or hypnotically; or psychodrama may be used. At the same time, these patients should work and earn. Oddly enough, some of them have been able to put their hysteria to good purpose. They may earn as mediums in occultistic or hypnotic seances, or they may offer themselves for clinical demonstrations. Most of them, however, will be able to earn in more average and accepted jobs.

Never should the average hysteric with obsessive-compulsive traits be hospitalized. Hospitalization is identical with doom. So long as these patients have to stay in the hospital, they will not adjust because there is no reality for them to adjust to. Hospitalization may be necessary, as a form of elimination, for criminal psychopaths—but not for the average compulsive-hysteric patient.

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EDITORIAL COMMENT

DIES IRAE, DIES ILLA

A first need of the atomic age may be a new Savonarola, or perhaps a whole new sect of reforming zealots, to preach to mankind of the depths of wickedness to be found in the human heart.

We who live today have just witnessed the most awesome discovery since our subhuman ancestors found out how to use fire. The great prehistoric inventions of the lever and the wheel, the first domestication of animals, the discovery of metals, and the modern developments of water, steam and electric power are in no way comparable to the atomic dissolution of Hiroshima by tapping for the first time the almost limitless power at the hearts of the sun, of Sirius, of Arcturus, of Vega and the outer stars.

It is almost certain that constructive use of this new power can transform our world—perhaps commencing in a decade or a century—into something this generation would find unrecognizable. The age of Buck Rogers and a great deal more seem just beyond tomorrow. Atomic energy is not only vast beyond ordinary concept but for most human purposes may be practically as inexhaustible as the power which men have dreamed of since ancient times under the name of perpetual motion. Once suitable materials and apparatus—metals and machines—are adapted for control and direction of this tremendous force, the future world may possess more resources for the comfort and the progress of all its inhabitants than present imaginings can entirely compass. We, our children or our grandchildren may see atomic watches which will run for generations without winding; ships, trains, automobiles, planes and rockets, powered by pocket-sized, pocket-weight motors which will need no refueling for years; an economy in which coal, oil and waterpower are obsolete, gold and platinum transmuted from other elements so easily they will no longer be precious; a world social, economic and political structure rebuilt on foundations of atom power and conditioned by the location and control of deposits of uranium, and perhaps other minerals. Unless there are unforeseen conditions, preventing human travel in space, voyages to Mars may become not only possible but commonplace; men from earth might even colonize that admittedly chilly planet if conditions there are as astronomers currently believe; and they might well explore other worlds if protection against poisonous atmospheres and against such contrasts of extreme heat and the cold of outer space as are to be found on Mercury and our moon could be achieved.

As laymen in atomic science, we may imagine that unlimited warmth for habitation and workshop might be achieved for the whole world if shafts could be pierced by atomic power to tap the internal heat of the planet. And if a small bomb can disintegrate a city or a desert surface, might not differently applied power in great volume melt the polar ice caps and reveal warm new lands for farms and cities? Easy transmutation of the elements might provide fertilizers which would bring undreamed of abundance through revolutionizing the earth's basic agriculture. Fancies which a few weeks ago were only in the deranged mind or in the imaginings of the pseudo-scientific fiction writer may no longer be impossibilities. The remote grandchildren of that first archaic savage who hunkered close to the miracle of fire in fear of the supernatural forces of the dark are now indisputable masters of this planet.

The masters of this planet, however, are something of evil beasts, murderous, selfish, lustful and destructive. Man has managed to get along with his fellows as well as he has done, only because his evil qualities are not the whole story. For, besides evil, he possesses—in his painfully developed and carefully cultivated super-ego, or conscience, or divine spark, or soul, or whatever one may call it—such qualities as kindliness, unselfishness, self-sacrifice and ability to construct as well as to destroy. Yet the evil has all too often been uppermost; we have just lived through an outburst of it unexampled in world history. And man, creature of two aspects, untrustworthy master of a world, has never eaten of the true Tree of Knowledge before, has never before been possessed, like the gods, of the knowledge of good and evil which is part of unlimited power over life and death; neither he nor any other earth creature has ever before been able to plan the making over of the entire globe or has possessed the ability to encompass its complete destruction.

Certain of the implications of man's fearsomely destructive use of atomic power have already been widely discussed publicly and with authority. We are informed that there is no adequate present defense against atomic bombs and none at all against atomic rockets; and if military forecasts that defenses will be developed are predicated on the fact that defenses have always been found against new weapons in the past, we who are not atom physicists may be forgiven for some skepticism. The counsel that we hide our cities underground is pure despair; however deeply man hides himself, we fail to see any assurance that sufficient force cannot be developed to hound him to his holes and disintegrate him there. And our military authorities also warn us that within a few years it may be possible to grind the people of a nation into atomic particles without a second's warning by rocket bombs launched half a world away.

With these facts, it seems a reasonable supposition that the era of fully "independent" nations as we know them today is fast disappearing; our present social and economic structures from American free enterprise to Russian Marxism will very probably be modified to fit an age of new dangers and new achievements; the pattern of personal life will be changed; the structure and method of science will be altered. Either this, or we can continue as we have always lived, pretending there is nothing new in the world, until destruction is visited upon us. At present, the holders of the atom bomb, whether they wish it or not, are the potential rulers of the world. If good luck, or destiny, or a kindly providence, or the hand of Almighty God had not withheld from Hitler the secret of the atom, that monster could, in 1939, have enforced his will by erasing every human being who openly opposed him from the face of the earth. An American Hitler could do this in 1945. Three or four months, or years, or decades, from now, when the feverishly working scientists of other nations solve the same problem, or when spies succeed in buying or stealing the secret, a second group or more will have the power to strike without warning, to destroy without warning, not only the peoples of the earth, but if the aggressors choose, a large part of the planet they live upon.

We agree with those students of the human race who think that man is no more to be trusted with the atomic power to destroy himself than a Rhesus monkey with fire to devastate his forest. We have no definite program to prevent man's very probable misuse of that power, and we do not intend to suggest any. It is silly to suppose that this or any other scientific fact can be long kept secret. And current proposals, such that as nations should simply "outlaw" atomic weapons would seem to many of us to be too childish for even sardonic laughter were it not for the terrible fact that the mental attitude which makes such suggestions possible was one of the important causes of the just-concluded war—the belief that men or nations can be trusted after "taking the pledge" or that promises can be relied upon without the most stringent means to enforce them. One sees immense difficulties, too, before the proposed United Nations organization can be set up to supervise world atomic research and world use of atomic power. Even Americans and Britons would like it better if it could be assured that all members of the power authority would be altruistis; and it may take extraordinary measures to bring other nations into willing adherence to the plan. And while it seems unlikely—even without such authority—that the present holders of the atomic secret would attempt to coerce the world, even for peaceful ends, it seems equally unlikely, without such an authority, that they would trust others with the knowledge to do so.

The benefits of atomic power may be years, decades or centuries hence;

its threat to mankind is immediate. We think that some sort of planetary control is inevitable but will be most difficult to achieve and that, both as a measure to persuade the world's peoples of its necessity and as something of a temporary safeguard until some sort of stable control organization is achieved, too much emphasis cannot be laid on the sadistic, destructive and altogether evil capabilities of the human race. Consider the resurgence of Germany after World War I. We are naturally aware of numerous factors leading to it, including political and economic developments as well as deeply unconscious motivations arising from the guilt feelings of the Allied conquerors; but we think that perhaps the most important general phenomenon which paved the way for Naziism was the almost universal tendency to adopt a "sweetness and light" view of human nature. It is difficult for the mind to accept, in the abstract, the realities of human aggression. A play therapist wrote recently of a child who, after repeatedly "killing" a "Hitler" doll, picked it up and embraced it: "This one," he said, "is a good Hitler." So after World War I, we could not conceive—in the abstract—of bad and dangerous people. The surviving Germans were "good Germans," were "people just like us who had been misled;" Mussolini was a really benevolent, if forceful, character who "got the Italian trains to running on time;" and, at the other side of the world, the Japanese were fundamentally, quaint little, friendly little, good little people who surely couldn't approve as a whole, or even be informed of, such matters as the doubtlessly exaggerated rape of Nanking, which was, anyway, the work of a mere handful of militarists. And so to World War II.

We suggest that in the atom-shattered wake of World War II it might serve an exceedingly useful purpose to place all possible public emphasis on what psychologists frankly admit is only a partial truth and one which under other circumstances it would not be good mental hygiene to stress. That is: There are no good Germans. There are no good Japanese. There are no good Englishmen, Frenchmen, South Africans, Russians, Chinese, Turks or Italians. There are not even any good Australians, Canadians or Americans. All this, that is, as far as trusting any of them with atomic power is concerned!

It is already forecast by persons in a position to know that the military occupation of Germany will be far shorter than was originally intended. It is already being said that the Japanese will be harmless with their military caste eliminated. The "sweetness and light" view of man's nature seems to be returning after the bloody and agonizing close of an unhappy quarter-century. One presumes that, however this optimism spreads, the United Nations will retain enough elementary common sense to prevent the open

reestablishment of atomic research in the defeated countries. But what about secretly financed activities by such individual German and Japanese scientists as may not be adjudged war criminals? No private individual or private group, scientific, political, social or commercial can be trusted with such vast uncontrolled power. And aside from former enemy countries, there are individual scientists and public and private laboratories in Great Britain, France, Russia and America. Laboratories also certainly exist, and more could be established, in Senor Farrell's Argentina and Senor Franco's Spain.

If we are to have even a small measure of protection for ourselves, we think the world must be convinced of the reality of the evil within man and of the imperative necessity of mobilizing and uniting the good which is also within man, of mobilizing and uniting the constructive elements of the whole civilized world to guard against the evil. We need evangelists to spread the warning that the Evil One is walking up and down the earth and to and fro upon it; and to spread the doctrine that the sand is low, that man must unite now against the Evil One or die. Neither the mechanism nor the nomenclature of the force we must fight is of immediate practical importance. Some of us may regard it as an instinct and label it "death" or "aggression;" but the devil, Satan, Beelzebub, Old Scratch, Shaitan, the Old Serpent, innate human depravity, or original sin might answer about as well for the present purpose. And we need not conceive of ourselves as anointed and ordained to spread this gospel. For disseminators of this particular truth, preachers, priests, prophets or politicians might do at least as well as, and get a far wider hearing than, psychologists and psychiatrists.

What is vital, as we see it, is to use all means at our command to combat easygoing and optimistic views by demonstrating that mankind is possessed today—as fully as when Hitler was in power—of fundamentally evil and utterly destructive possibilities and that the devising of efficient world-wide curbs on them is of more import than any other present human need or any present human institution. If we thus create widespread neurotic guilt and anxiety feelings, the evil is less than destruction; and man may be granted time in which to cure himself by stressing his good qualities again, once the major menace is controlled.

We do not wish to be misunderstood as maintaining that a "sweetness and light" concept of the human nature of our recent enemies, our present allies and ourselves can bring about World War III. We do not anticipate World War III. We think it far more likely that it would bring about the Day of Judgment.

A WONDERFUL IDEA—IF ONLY IT WOULD WORK!

One may be relieved to know that United States Circuit Court Judge Jerome Frank specifically disclaimed any jocularity in his suggestion to the third annual Conference of Scientific Spirit and Democratic Faith last May that "major" government administrative officials be "required periodically to consult government psychiatrists."* It is reassuring to note that there is no levity intended, for inherent in the situation itself are so many humorous possibilities that it may be difficult to treat with proper respect a proposal which ought to be taken seriously. One has only to imagine the psychiatric consultant reminding a Carolina governor that it has not been such a long time after all between drinks, suggesting to a peppery mayor that certain of his recent acts have been determined by his tantrums, or attempting to influence a government engineer whose current burst of hypomania threatens to wreck a huge construction project. And, if that is not sufficient, one may proceed to imagine the psychiatrist's own government superpsychiatrist attempting tactfully to persuade him to suspend psychotherapeutic activities until the subsidence of his own present manifestations of megalomania.

These few raucous hoots are not intended to laugh Judge Frank's suggestion out of his own or any other court. For the judge is extraordinarily right, of course, when he declares that "the best of men at times become the creatures of inner drives and obsessions of which they have no awareness. An occasional chat by an overworked official with a government psychiatrist would make government run more smoothly." He observes, "My experience in government leads me to believe that a very considerable part of the friction between government departments, if one peered behind the rationalizations, could be traced to personality difficulties of one or more of the disputants." If the worthy judge were to have extended his comments to other matters than departmental friction and his notes on personality difficulties to other officials than administrative, an impressive case could be made out for his chief contention. In the old German Reichstag, for example, if a government psychiatrist's report could have led to the enforced retirement of Hitler, the world might have avoided its bloodiest war. If similar psychiatric reports could have been made and acted on in the United States, this country might have adhered to the League of Nations a quarter-century ago. In the years following, the Senate would have been spared some of its more spectacular members. We might have rid ourselves of half a dozen mayors, a few Congressmen and a governor or two. The judge who presided over one of America's most sensational *causes célèbres*

*New York Times, May 27, 1945.

would not have presided—even though his conduct were exemplary in the courtroom itself, as indeed it was—for his personality difficulties outside of court were notorious; and there might have been no *cause célèbre*.

This is by way of saying that Judge Frank very probably has a fine idea if any way can be found to make it work. That is, it surely would be desirable to make universal and compulsory, for our public administrative officials, the psychiatric service and advice a fortunate few now seek voluntarily as private patients. It would be good for them, for their colleagues, for their subordinates, for the efficiency of their services and the welfare of the people they serve.

But one may wonder if this proposal is not another contribution to that extensive and ever-growing list of splendid ideas which have just one thing the matter with them—i. e., they won't work. This one could, and probably would, work in certain limited fields. For instance, as Emilio Mira, who was the psychiatrist in charge of the program, reports: The army of the pre-Franco Spanish Republic, having lost many of its professionals and traditionalists to the rebels, was prevailed upon to break with custom and accept a psychiatric service to guard the mental health of its leaders. The psychiatrists of this service did for the colonels and the generals much the same sort of thing Judge Frank proposes for civil administrators; such a service in our army would be useful and might be practical, even though the fighting is over; and it might be practical to establish one for, let us say, the junior administrative grades of civilian public employ as well. But the higher grades are as likely to need such a mental hygiene program as the lower; and the higher grades are generally well out of reach of anybody with lesser influence than a high elected official—or, anyway, the political boss of at least six counties. For the ordinary medical specialist, the higher administrators are untouchable.

Perhaps Judge Frank or some other expert in government can think of some sort of machinery which would make his suggestion workable; but we think the plain, simple medical specialist will beg to be excused from any part in figuring out such a setup. His task will be quite enough, thank you, when he starts to work if and when such a project is achieved; he'll need the personal immunity of a medieval king's jester for one thing. We think he would wish to leave to other experts, too, the matters of how to safeguard the new organization from the personality faults of the psychiatrists themselves and from abuse of their medical authority. He knows such things can happen; and, if we ourselves know the American medical man at all, he should see no great improvement over democracy, or even over demo-beaurocracy, in the establishment—if we may be forgiven such a schizophrenic neologism—of a psychiatocracy instead.

BOOK REVIEWS

The Yearbook of Psychoanalysis, Volume I. SANDOR LORAND, M. D., Managing Editor. 370 pages, (large octavo). The International Universities Press. New York. 1945. Price $10.00.

An authoritative contribution on psychoanalysis is timely. To a large extent, the hue and cry against Freud and his theories has died out; and, more and more, the newer textbooks on psychiatry stress his concepts and his nomenclature in discussing the symptoms and characteristics of the psychotic. The discipline termed psychosomatic medicine, growing daily in popularity and interest, would have neither form nor substance without the concepts of psychoanalysis. But for all that, a raucous clamor is raised occasionally against the theories of the unconscious by someone who just misses a comprehension of the subject—as recently occurred in a discussion on the life of William James. No, psychoanalysis is here to stay; and, like the atomic blast, though it may be distasteful to many people, it will illuminate science and contribute to human welfare.

"The Yearbook of Psychoanalysis" is a useful contribution to psychiatry; and it is hoped that succeeding volumes will appear biennially, or at least frequently. It is, of course, well known that much that is written and spoken under the guise of psychoanalysis is untrustworthy and confusing to general physicians. Almost anyone with a hazy idea of what he is talking about and a still hazier idea of the subject can get his writings published under the name of psychoanalysis; and even respectable medical journals occasionally let something slip in which is speculative and unsound.

But the situation is even worse than that. Dr. Brill, in his introduction to the present volume, writes: "Of late, however, there appeared societies and individuals who offer the people better, cheaper and quicker psychoanalyses. Some of these purveyors may be well meaning but mistaken physicians while others are definitely of an entirely different caliber." These remarks are quite true, and it was to meet this situation that the "Yearbook" was devised. It is made up of 21 articles already published (some of them going as far back as 1942), prepared by physicians qualified for the task, and so it may be accepted as an authoritative presentation of psychoanalysis of the present day.

The articles cover a wide range of subjects—some theoretical, others clinical and practical. For example, psychoanalysis must be revived in Europe, which was its original home. Fortunately, under the tutelage of

Dr. Brill and the membership of the American Psychoanalytic Association, it has experienced during the war years a period of vigorous growth and development. The articles printed in this volume tell the story.

Modern Psychiatry. By WILLIAM S. SADLER, M. D., F. A. P. A. 896 pages. Cloth. The C. V. Mosby Company. St. Louis. 1945. Price $10.00.

Dr. Sadler of Chicago, psychiatrist and author, is well known to the medical and allied professions through his papers and books dealing with psychology, psychiatry and mental hygiene. The book reviewed here is closely related to his "Theory and Practice of Psychiatry." In it, he devotes the introductory chapter to psychosomatic medicine and lays special stress on personality problems and therapeutics.

The author attempts to present to us the story of "personology," a term coined to embrace "the difficulties human beings have in adjusting themselves to life." (See preface.) He gives psychosomatic medicine its due recognition.

"Modern Psychiatry" has four major parts: I. Personality problems; II. Psychoneuroses; III. Psychoses; IV. General therapies. An appendix discusses schools of psychiatry. A valuable bibliography and a glossary for references are well chosen.

There is a good deal of worthwhile material collected in these 61 chapters, and the author's mental hygiene approach will appeal to those dealing with minor mental aberrations of their patients. The common sense gospel of child guidance and mental hygiene, the stress on sound training and education, may be of considerable assistance in the theory and practice of preventive medicine.

The book as a whole cannot be regarded as an unfailing beacon; it may be an adequate guide with reservations. The *Leitmotif* of a dynamic psychological credo appears to be missing or perhaps has become lost in an altogether too eclectic and too opportune presentation. The serious student of psychology and psychiatry is left with a feeling of perplexity, especially after studying the chapter on schools of psychiatry.

In exemplifying the last assumption, the Freudian school of psychiatry in particular does not receive a fair deal. Freudian concepts are accepted and rejected in an ambivalent and arbitrary selective way. Non-Freudian psychologies also have to render selective service. The discerning reader does not need a not too successful homogenized psychological medicine. Analytical terminology had better be used the way the analyst intends it and not as a matter of convenience. Also, in a book which has pretentions

to be modern and presumably scientific, obsolete terms such as "nervous breakdown" and "insane asylum" are out of place.

A revised edition could considerably enhance the value of "Modern Psychiatry" by more objective presentation, by omitting repetitious and lengthy discussions and also by careful proofreading to eliminate minor errors. Descriptive psychiatry, as the medical student is called upon to master it, as well as the rôle hospitalization is playing therapeutically could have more consideration.

The general practitioner, the social worker, the teacher and some psychiatrists may cherish "Modern Psychiatry" as a guide and reference book when taken *cum grano salis.*

War, Crime and the Covenant. By GÉZA RÓHEIM, Ph.D. With an Introduction by A. A. Brill, M. D. v and 160 pages with index (large octavo). Cloth. Journal of Clinical Psychopathology, Monograph Series No. I. Medical Journal Press. Monticello, N. Y. 1945. Price $3.00.

The basic factor in the outbreak of war is not economic but psychological. It is the same motivation, expressed against an out-group, as aggression turned inward against the self, or as violence or crime against a fellow-member of an in-group. The covenant is the union of the in-group males, symbolically brothers through rituals representing common participation in the mother's milk. Their union has fundamentally aggressive elements. The source of the aggression is ultimately the Oedipus complex, infantile hostility to the first stranger the child sees—the father. In war, the enemy or the stranger represents the father. The structure of the human psyche is basically repsonsible for international conflict—although it must not be assumed that other factors do not enter into it or that it has sole responsibility.

These views are developed brilliantly in this short monograph by the most distinguished of the psychoanalytical anthropologists. His data, derived alike from ancient tradition and ritual and from field work among modern primitives, are marshalled to support the view that world conflict as we have just seen it has psychological sources common to all mankind. Men do not fight primarily for food or living space but because of outbursts of innate aggression. Róheim finds aggression, the trend to separate, to be an innate human characteristic like the trend to unite, that both spring from the dual-unity situation of mother and infant where mother and child form at the same time a whole and two parts of a unity; that the trend to separate and the trend to unite, frustration and satisfaction, must alternate in human life.

Under certain forms of social organization, that is, certain forms of the covenant, aggression may be turned inward in Menninger's "man against himself" fashion, or it may manifest itself in crime. Róheim holds that recent years have demonstrated democracies, where there is regulated in-group aggression, to be fundamentally peaceful societies; while the totalitarian states, with in-group aggression sternly suppressed, "must head for war." Such explanations of war and its causes as economic pressures are, at least for the most part, rationalizations. The author, of course, would qualify this; he would not deny the strength or influence of such things as economic or environmental pressures; he would hold, rather, that the psychic apparatus through which man reacts to his environment is the primary reason for the way he reacts, the pressures of his surroundings secondary, the kind and direction of his outbursts of aggression governed by the peculiarly human characteristics of the means he must use with which to feel and think, the psychic means, that is, determined by the dual-unity situation of man's long babyhood. "Yet perhaps some day," says Róheim, "Reason may triumph. We don't know." Man must find some way to eat or incorporate symbolically an environment in which—since aggression cannot devour it literally—frustrations lead to wars. Róheim emphasizes that there is a human trend to unite, as well as to separate; perhaps he finds hope in this.

Any review which summarizes in this fashion is manifestly inadequate and manifestly unfair to an author; it involves distortion and perhaps unintentional misrepresentation; it is justified by the need to outline sufficiently to demonstrate its importance a thesis which deserves the closest attention of all who are concerned with the problem of how the human mind can cope with today's most menacing world. Róheim specifically disclaims having made any attempt to cover his vast subject completely. He notes, for example, that he has not discussed the death instinct, which "may still be true as a deeper underlying factor" of inward-turned aggression than the dual-unity situation of mother and child in infancy. "I have followed a thread through a labyrinth of facts," he writes, "without claiming at any time that the thread I follow gives a complete description of all the intricacies of the labyrinth." The reader will be well repaid for following that same thread.

New Directions in Psychology—Toward Individual Happiness and Social Progress. By SAMUEL LOWY, M. D. 194 pages. Cloth. Emerson Books, Inc. New York. 1945. Price $3.00.

This is a book by an experienced psychiatrist and psychoanalyst, a pupil of Stekel, who is now living in England. He believes that the recent ad-

vances in analytical and social psychology have not been placed before the people in a way that would be understandable to them.

It seems to this reviewer, however, that the title is too comprehensive and may be on that account, misleading. The reader would look in vain for novel or hitherto unrecognized applications of psychological principles to social advancement and individual success. Many applications of such principles are to be found in the text, but they have been presented to the professional reader already. The author in his preface, states quite plainly that all the problems dealt with in this volume are presented in the light of the latest views advanced by modern writers on social psychology.

Dr. Lowy's views are sound and in harmony with those of authoritative writers. His aim is to place scientific theoretical concepts at the disposal of educated persons and to point out how these concepts apply to the practical affairs of everyday life. He hopes readers may, thereby, gain insight into their conflicts and repressions and be relieved of many hindrances in their daily lives. To make this easier he has not written a formal treatise but has adopted a different method of presentation.

The reviewer believes a better title for Dr. Lowy's book would be something like this: "The Psychiatrist Looks at Life and Love," for topics within this sphere make up the 26 short chapters, some of which are only two or three pages long, and no one of them is directly related to its preceding chapter. Some of the subjects are: "The Need for Social Psychology;" "Hatred and Aggression;" "Interference with Other People's Lives;" "Children and Parents;" "Marriage;" "The Emotion of Man;" "Sexuality in Its Cultural and Social Aspects."

The author's plan follows that of the essay. Indeed, these short chapters could be described as a series of essays. He writes down a proposition or relates a circumstance, develops his theme with comments upon it and draws lessons or conclusions. The book is well written; and technical terms, when necessarily used, are defined so that almost any educated person would be able to read and profit by the text.

Men, Mind and Power. By DAVID ABRAHAMSEN, M. D. 155 pages. Cloth. Columbia University Press. New York. Price $3.00.

This treatise is an admirably digested and compactly presented review of the psychopathological factors which brought about the rise of Naziism, with the cruelties, the treacheries, the Niagara of blood spilled in the war, the calculated mass atrocities and the ruin of most of northern and central Europe which came in its wake. Dr. Abrahamsen, Norwegian-born psychiatrist and authority on criminal psychopathology, now with the Department of Psychiatry of Columbia University, has had first-hand contact with Nazi

ruthlessness and with the treason and collaboration which abetted it abroad, for he organized and headed a field hospital when the Germans invaded Norway, escaping to America through good fortune alone when Norwegian resistance was crushed.

Like Fromm, Brickner and most others who have studied the problem from a background of dynamic psychology, Abrahamsen believes Naziism was made possible by an essentially maladjusted German society and German mentality. Since time immemorial when the Teutonic barbarians lived in the great stretches of their dark forests and a trend toward banding together was conditioned by geography, German society has been closely knit, patriarchal, its members extremely interdependent and individually insecure, its typical family pattern that of the tyrant father, its standard of social conduct subservience to the superior, arrogance toward the inferior, its loss of individual initiative compensated for by sadism and by identification with the tribal leader, its suspicion of the outlander developed until the Germans as a whole have no capacity for identification with non-German human beings. These traits have been so developed and accentuated through so many centuries, Dr. Abrahamsen thinks, that they are now fundamental to the German character. They would certainly seem to provide the bases for much of Hitler Germany's activities, with Naziism the psychological instrumentality for action rather than the instigator. For example, the impossibility of identification by the German with the non-German would appear to explain, not only how a supposedly civilized people could engage in the planned mass tortures and murders of the recent war, but would seem to indicate in addition that Germany under regimes far different from the Nazi would still be capable of this inhuman behavior.

In Hitler and his fellow-gangsters, which is what this author considers them, a psychopathic nation found congenial psychopathic leadership; Nazi psychology and Nazi politics met German emotional requirements; Nazi hatreds, cruelties and violence provided the sadistic outlets a deranged psyche needed for relief. Dr. Abrahamsen, who has specialized in the psychopathology of crime and who is the author of a penetrating analysis of the psychological background of antisocial behavior, "Crime and the Human Mind,"* published last year, discusses—as is natural—the behavior of Nazi leaders and foreign collaborators, in the light of his own studies. He regards "Hitler, Himmler, Goering, Goebbels, Quisling, Laval, and many other first-rank collaborators . . . as incurable criminals;" and he makes it plain that he is considering them as common criminals, murderers, arsonists, rapists and such, not as what we have been euphemistically calling war criminals.

*Reviewed in PSYCHIAT. QUART., 19:3, 526, July, 1945.

Dr. Abrahamsen gives with brevity notes on some of the familial, sociological and characterological factors in the development of these supercriminals. Hitler, Goebbels, Himmler, Quisling and Laval had emotionally insecure and unhappy childhoods. Hitler, Goering, Himmler and Laval hated their fathers or were jealous of them. The ambitions of Hitler, Goering, Goebbels, Himmler and Quisling met with severe frustrations when they were young men. Refuge from frustration was sought in fantasy and/or fanaticism by Hitler, Goebbels, Goering, Himmler and Quisling. The course of Goering's neurosis was influenced adversely by addiction to alcohol and narcotics, that of Goebbels by the fact that he was a cripple. Hitler and many of his followers were imbued with such hatred of lawful society as to place them beyond its bounds. Hitler, Goering and Quisling all engaged in dubious or downright criminal activities before the Nazis assumed power; Streicher was "perverted;" Laval had the fatal character defect of defeatism. Others of the prominent Hitler followers were Von Papen, Hess, Ley, Von Ribbentrop and Doenetz. With the other important party leaders they shared one trait in common; they were all maladjusted to life and society; and their careers were swayed by their inner conflicts. The Germans among them, for the most part, exhibited to exaggerated degrees characteristics to be found widely among lesser Germans; the traitors and collaborators were overcompensating for frustrations, like Quisling, or were more rarely, personally ambitious defeatists—expecting defeat and seeing in defeat a chance for self-advancement—like Laval.

Dr. Abrahamsen would punish the survivors of these major criminals severely, the lesser criminals of all degrees, including the financial wreckers and looters of occupied Europe, according to the nature of their crimes—and he estimates there must be betwen four million and six million German war criminals in all—then he would consider the remaining Germans to be on probation and would start a long process of reeducation, lasting two or three generations, "the next seventy-five years" or so, since it would not be possible to attempt individual character reconstruction, with each German undergoing individual psychoanalysis for an hour a day every day for the next one to three years. He is likely to see the first part of his program realized; the major Nazis and other war leaders will certainly pay the death penalty; and it seems likely that the Russians at least will punish a good many of the lesser by long isolation from their countrymen in general for terms of hard, supervised labor as Dr. Abrahamsen suggests, even if they punish some in this process whose guilt may be doubtful. But one may doubt the victors' will or their likelihood of enforcing the long educational process which other writers on German psychology agree with Dr. Abrahamsen is called for; the western allies do not seem to agree among them-

selves or with the Russians on what, if any, reeducational steps to take; and it looks as if everybody might be tired of the business of military occupation long before any such program as the one outlined in this book could be completed, or perhaps even get well under way.

Yet dynamic psychologists who have studied the problem, not only those whose books have been published but many who have given much time and energy during the war years to attending special scientific meetings where the subject has been discussed, are virtually unanimous in holding that Germany must be reeducated intensively and for a long period. Pointing to the vital necessity of a firm, long-term, constructive program of dealing with Germany, Dr. Abrahamsen asks, "Can we go on running the risk of a new war every twenty years?" He does not discuss, perhaps because it would be out of the province of this book, the question of whether the effective international organization which optimists hope to form might not minimize the danger of periodic German outbreaks, while permitting the German mind to develop along whatever maladjusted lines it may pursue.

Negative, defensive measures cannot serve in today's crisis, Dr. Abrahamsen holds. We must convince the Germans, and incidentally ourselves, that freedom and peace are dynamic things, that they are forces which demand that every individual struggle and fight for them if today's bad world is to be made into "a good one tomorrow." This is surely a creed worth the utmost efforts of all men of good will. One may conclude also that, whatever the fate of the proposals advanced, the little volume which concludes with this creed is not only pertinent commentary on the subject now in hand but is a worthwhile contribution to the general literature on the psychology of war and peace. It is to be particularly recommended to the general reader, for it is unusually straightforward and concise, and it is comparatively free of the technical language which is so confusing to those not versed in the specialties connected with dynamic psychology and psychiatry.

Mental Abnormality and Crime. Edited by L. Radzinowicz, LL.D., and J. W. C. Turner, M. A., LL.B. 316 pages. Cloth. Macmillan and Co., Limited. London. 1944. Price $3.75.

This book is made up of 13 essays on the general topic of mental abnormality and crime by prominent British authorities, among them two well known in America—Dr. D. K. Henderson and Dr. R. D. Gillespie. It is not a book on forensic psychiatry but its viewpoint is rather the clinical aspect of crime associated with mental abnormalities. It is a volume for physicians and sociologists rather than lawyers.

A brief preface by Prof. P. H. Winfield, K. C., LL.D., of the Faculty of Law, Cambridge University, directs attention to the need of such studies

for the guidance of judges and counsel in the British courts. Equally great is this need for the American courts. The notable lack of harmony in judicial attitudes and procedures in various parts of this country, in cases in which the accused is or may be suffering from some mental abnormality, is striking. The differences are doubtless due to the varying points of view of the courts and magistrates which in turn reflect public sentiment in reference to mental defects and abnormalities. Public sentiment with reference to mental deviations is also reflected in the degree and quality of mental hospital care available in the different sections of the country. Where the provisions are poor and inadequate and have been so for long periods, the attitude of courts and juries is often, to put it mildly, crude.

While the essays contained in this volume do not answer all the questions —if they did attempt to do so, many of them would inevitably be wrong— they make a beginning or they make progress in attempting to reach understandable views and opinions as to: mental variation and criminal behavior, psychoses and psychoneuroses and criminal responsibility, functional nervous disorders after injury, sexual offenders, certain aspects of juvenile delinquency, criminal behavior with reference to military life, and many other topics. The views expressed are in accordance with the best authorities, and they take into account modern terminology. Two of the reports are of work actually done in the diagnosis and treatment of delinquency in the institute for the Scientific Treatment of Delinquency during the five-year period 1937-41 and of work done in the Exeter Child Guidance Clinic. The former is by Dr. Edward Glover and the latter by Dr. R. N. Craig.

This volume is number two of a series of treatises on criminal science, planned by the Faculty of Law of Cambridge University. Other volumes will deal with the modern approach to criminal law and with the after-conduct of discharged offenders. The editors of the series and Prof. Winfield are to be congratulated upon their enterprise in putting this series at the disposal of the legal and medical fraternities.

The Sexual Revolution. Toward a Self-Governing Character Structure. By Wilhelm Reich, M. D. Translated by Theodore P. Wolfe, M. D. xxvii and 273 pages. Cloth. Orgone Institute Press. New York. 1945. Price $3.25.

Wilhelm Reich is an impassioned revolutionary. He hates authoritarianism in any form, capitalist, Fascist, Communistic, religious or familial. He holds that a great revolution in "cultural" living has been in progress for some years and is still going on. It is not an economic class struggle as the Marxian mechanists would have it, nor a conflict of national or other

politically-organized entities; it is the battle of those with a freedom character-structure against those with an authoritarian character-structure, of the free or of those who would be free against the dictators, who, Reich observes incidentally, "arise from the proletariat." Reich's rôle in this great cultural revolution is to battle for sexual freedom. What he means by this would probably be described by churchmen as unchecked immorality, by the framers of current law and order as unlimited license, and by totally disinterested sociologists—could such mythical creatures be found—as socially sanctioned and encouraged promiscuity.

The past and the present views of Reich on the importance of sex in physical and mental health are well known. If ironical detractors of psychoanalysis can jeer at Freud as "the man who discovered sex," Reich can be called the chief affirmer, the high priest and the archprophet of sexology. Free and full sex lives, Reich holds, are remedies for mental derangements and social ills. His psychotherapy is directed toward bringing his patients to complete orgastic potency. He disagrees with the thesis that sublimation is a useful and essential process, responsible for human achievement and civilization. Repression and suppression of sex impulses are harmful. Orthodox psychoanalysis, often bitterly attacked by those ignorant of its principles and practices for its "undue emphasis" on sex, is criticized by Reich as "an *anti*sexual theory"—and those are Reich's own Italics.

The author holds, of course, that today's (European and American) social order is generally authoritarian and that the "sexual crisis of youth" remains unsolvable "on a mass scale" within "this framework." Since he also believes that sexual abstinence during adolescence is harmful and that masturbation is, in the end, unsatisfactory and productive of neuroses, he also believes that it is necessary to change the social framework. He remarks that without different sexual education of children and without solution of the problems of housing and contraception "it would be irresponsible and dangerous simply to tell youth to go ahead and have sexual intercourse." The necessary new social framework is barely outlined. Reich believes we are moving toward an "*internationalism without any ifs and whens.* The rule over peoples by politicians must be replaced by a scientific guidance of social processes, what matters is human society and not the state." The reader will perceive without difficulty that the atomic disintegration of Hiroshima supplies punctuation for this.

Exactly how Reich's international society would be organized, this volume does not state in any detail, although there are a number of specific recommendations: Begin collective education of children before they form "destructive attachments to the parents, that is before the fourth year of

life;'' train sexologists scientifically; suppress pornographic literature and *mystery stories* (the Italics, for once, are the reviewer's); manufacture contraceptives scientifically and without profiteering and make them available generally; let the authoritarian form of the family ''inevitably disintegrate'' and be replaced by the ''natural family,'' a term which deserves more explanation than the author gives it; free women economically and from the responsibility of rearing children; educate to make human life self-regulating; strike all the restrictions from sex and permit individual self-government of sexual impulse and sexual conduct; create a ''sex-*affirmative*'' ideology; build up as a new economic and social superstructure a free work-society—perhaps Marxian, but free—Reich has no patience with authoritarianism in any form, he is severely critical of that of Russia.

This adds up to a social and psychological study which deserves far more attention than this reviewer can allow, or than most persons are likely to give to it. The proposals are radical to the extent that it may be well to remark that they are not presented in the form of an hallucinatory, ''crackpot'' Utopia. That is, Reich recognizes that they are not immediately practicable. He recognizes the social, economic, religious and political difficulties on his revolutionary road and emphasizes that a long transition period of education and slowly changing legal structure would necessarily precede establishment of his new social order. The character-structure of people in general would need to be altered, and he makes this fact plain. He might well have given it considerably more emphasis in a work intended for general reading, for, as a psychotherapist, he must have encountered numerous patients who were prevented by their personality-organizations from adopting courses of conduct which, they believed with intellectual insight only, were rational and warranted, particularly in sexual matters. It is a problem seldom recognized at all by the lay ''sex-reformer.''

The present reviewer will excuse himself from any attempt to evaluate Reich's suggestions or to comment on the validity of their psychological bases. It is unusually difficult to view this work objectively, not only because of its subject but because of the author's background. His scientific and therapeutic theories are as revolutionary as the social organization he proposes here. In physics, he contends that he has demonstrated the existence of a new form of energy, the ''orgone,'' which he has used in physical medicine to treat cancer. In biology, he asserts that he has generated life from inert matter. In psychiatry and sociology, he has a long and stormy record. Once a valued pupil of Freud, he voiced differences of theory so radical that he is now at open war with the psychoanalysts. Sympathetic

with Marxianism, he criticized the failure of Russia to maintain her sexual, as well as economic, revolution in such unsparing terms that he is now *persona non grata* to the Communists. He fled from Germany to Norway to escape the Nazis and from Norway to escape them again. When he arrived at New York as a refugee, his admission to this country was long delayed while the government investigated charges against him of immorality. Those least in sympathy with his scientific, therapeutic and social views will find a fascinating demonstration of how to make enemies and enrage people in the volume here reviewed.

Adult Adjustment of Foster Children of Alcoholic and Psychotic Parentage and the Influence of the Foster Home. Memoirs of the Section on Alcohol Studies, Yale University. No. 4. By ANNE ROE, Ph.D., and BARBARA BURKS, Ph.D., with a chapter on sibling adjustment in collaboration with Bela Mittelmann, M. D. 164 pages, with 53 tables, three appendices and index. Paper. Published for the Section on Alcohol Studies by the Quarterly Journal of Studies on Alcohol. New Haven. 1945. Price $2.00.

This is a brief but very intensive and careful study of data tending to throw light on genetic and environmental factors in alcoholism and mental disorder. The subjects are 78 persons, now 21 years old or over, who were placed in foster homes in childhood through the New York State Charities Aid Association. They were selected by classification of own parents, as: alcoholic (the father or both) 36, normal (both) 25, psychotic (one or both) 11, and one alcoholic, the other psychotic 6. In addition, the special study of siblings with Dr. Mittelmann included four children whose parents were epileptic.

The investigators found that "as regards their present adjustment, there are no significant intergroup differences, and there are as many seriously maladjusted among the normal-parentage group as there are among the alcoholic-parentage group." Among children with alcoholic parents, the report notes that "there are no alcoholics, and only three of them use alcoholic beverages reguarly." None of the children of psychotics "is now psychotic, although some are maladjusted and a few seriously so. . . . all are beyond the ages at which schizophrenia normally appears or is foreshadowed and, with one possible exception, there is little likelihood of development in any of these subjects." And the report notes that there seems no reason to anticipate any greater incidence of the other psychoses than in the general population.

The writers consider the lack of alcoholism of particular significance, inasmuch as other studies have indicated that between 20 and 30 per cent of

the normal children of alcoholics who are brought up by their own parents develop alcoholism themselves. (Since the study deals only with children who were considered "placeable" in foster homes, those from alcoholic families with conspicuous mental or physical stigmata, or those obviously defective themselves as children—among whom the general incidence of adult alcoholism is even greater—are not included.) The alcoholic parents appear to be regarded by the investigators as generally comparable to the "normal" parents, although some crime and sex deviation are noted, and average intelligence may be lower; and the children appear to be comparable to those of normal parentage, except that there seems to be "somewhat better innate ability" in the normal-parentage group. Adjustment in all groups seems to have been conditioned largely by the amount of love and of lenience given to the children in their foster homes; and it should be noted that because of placement at a generally later age, the foster homes of the alcoholic-parentage children do not seem to have been quite so desirable as those of the normal-parentage group.

The authors say: "We are certainly justified in concluding that the high incidence of alcoholism and psychosis reported in the offspring of alcoholics cannot be explained solely on the basis of any specific heredity." One might properly consider this a commendably cautious conclusion, for on the face of the results the data seem such as to confound the geneticist and cause to rejoice what Earnest Hooton calls "the crude environmentalist," as far as inheritance factors in alcoholism are concerned. And the psychiatrist will regret that the psychotic-parentage group is not larger and its analysis—particularly as to types and malignancy of disorders—given in more detail here. But the authors note that whatever genetic influences may be found in alcoholism, the factors are evidently neither simple dominants nor recessives; and they warn properly that we may not be justified either in taking parents as a index of heredity or the home as an index of environment.

The organization of this study calls for comment. Dr. Burks and her assistants began surveying the literature and sampling the field in 1940, worked out and standardized case selection and interview methods in 1941, and did the field work in 1942 and the early part of 1943. After Dr. Burks' death in 1943, Dr. Roe, who had been a major collaborator with her in working out the methodology, assumed charge of the project. The three appendices include the details for classification of own parents, the interview schedules and the rating scale used for the interviews. Some of this material has already been used for other purposes than the current survey. It appears to be a model for painstaking, detailed and well-controlled field work. As an example of first-rate methodology, it should be of use and value to all persons interested in social survey field work.

NEWS AND COMMENT

SMITH ELY JELLIFFE, M. D., IS DEAD AT 78

Smith Ely Jelliffe, M. D., among the oldest and most eminent of America's neurologists and psychiatrists, died at his summer home at Huletts Landing at Lake George, N. Y., on September 25, 1945, at the age of 78. His death brought to a close an extraordinary career as practising physician, specialist, educator, editor and author, over a period of 56 years. From 1902 until his retirement last February, he was managing editor of "The Journal of Nervous and Mental Disease;" since 1907, had been editor, at first with the late Dr. William Alanson White as cofounder, of the "Nervous and Mental Disease Monograph Series;" and since 1913, had been managing editor of "The Psychoanalytic Review," also founded by him and Dr. White.

Dr. Jelliffe's career was one of prodigious activity. Born in New York, he was graduated from the College of Physicians and Surgeons at Columbia University in 1889, following which he did postgraduate work in Europe at various periods, during one of which he studied in Vienna under Freud, then combined teaching in New York with his medical practice. Prior to 1910, he held associate or full professorships in such widely different subjects as pharmacognosy, materia medica, psychiatry and neurology at Columbia, Fordham, and Post-Graduate Hospital and Medical School. As early as 1895, he was the author of a text on vegetable pharmacognosy, and he was writing on the same subject as much as 10 years later, revising "Butler's Materia Medica" during this same period. During his early years as physician, writer and teacher, he also found time to attend Brooklyn Polytechnic Institute and to add A. M. and Ph.D. degrees from Columbia to his M. D. His first professional interests were wide; he was author of a work on the histology and morphology of plants and one on the flora of Long Island, and from 1904 to 1918 was a coeditor of the "Encyclopaedia Americana."

By 1902, however, when he became managing editor of "The Journal of Nervous and Mental Disease," his interests were becoming crystallized in the specialties of neurology and psychiatry. He wrote on nervous diseases for "Butler's Diagnostics" in 1902, revised "Shaw on Nervous Diseases" in 1903, translated and edited Dubois' "Psychoneuroses" in 1905, wrote

"The Psychic Treatment of Nervous Disorders" in the same year. At this time, he was also editor of "Medical News" and associate editor of "The New York Medical Journal." He later collaborated with Dr. White on two important texts, the two-volume "Modern Treatment of Nervous and Mental Diseases" in 1913, and, in 1915, "Diseases of the Nervous System," which has been published in six editions.

In forensic psychiatry, Dr. Jelliffe became a nationally-known figure to the general public. In 1907, he had written "The Semi-Insane and the Semi-Responsible;" and in 1908, he was called as an expert witness in the second trial of Harry Thaw for murder in the shooting of Stanford White. A comparatively young professor of mental diseases at Fordham at that time, Dr. Jelliffe gave the testimony which has been generally credited with convincing the jury that Thaw was insane at the time of the killing, so sending him to Matteawan instead of to prison or to execution. Many years later, he appeared in another case which attracted wide public attention, the trial of Joseph W. Harriman, convicted of falsifying the records of the defunct Harriman National Bank and Trust Company, at which Dr. Jelliffe testified that Harriman was mentally incompetent.

Dr. Jelliffe was regarded as one of the leaders in the movement for the development of psychosomatic medicine, as one of the early advocates of psychoanalysis in this country, and as an authority on it. He was the author of "The Technique of Psychoanalysis," "Psychoanalysis and the Drama" and other publications on the subject. He was past president of the American Psychoanalytic Society and the American Psychopathological Society. He also received honors from his professional colleagues in the field of neurology, serving as president of the American Neurological Association in 1929 and 1930; and he had also been president of the New York Neurological Society. He was a past president of the New York Psychiatric Society and a life member of the American Psychiatric Association.

Aside from wide acquaintanceship among officers of the State institution medical staffs, Dr. Jelliffe had official professional relations with the New York State Department of Mental Hygiene; he was consultant neurologist for both Manhattan State Hospital and Kings Park State Hospital. When he retired from the managing editorships of "The Journal of Nervous and Mental Disease" and "The Psychoanalytic Review," he was succeeded by a Department psychiatrist, Nolan D. C. Lewis, M. D., director of the New York State Psychiatric Institute and Hospital. Surviving Dr. Jelliffe are his widow, the former Belinda Dobson, a son, Smith Ely Jelliffe, Jr., of New York, and three daughters, Mrs. Helena Goldschmidt and Mrs. Sylvia Stragnell of New York and Mrs. Winifred Emerson of Chicago.

DR. PAMPHILON BECOMES ASSISTANT COMMISSIONER

Walter M. Pamphilon, M. D., assistant director of Willard State Hospital, has been named assistant commissioner of the New York State Department of Mental Hygiene by Commissioner Frederick MacCurdy, M. D. He had previously been detailed as acting medical inspector, has been assigned to the inspection service of the Department and will be on duty in the New York City office for part of his time, besides assisting with the Department's program for postwar building. Graduated from the University of Toronto Medical School, Dr. Pamphilon entered the State service at Buffalo State Hospital in 1922. He had been at Willard since 1933, when he went there as first assistant physician, later being designated as assistant director.

Kenneth K. Slaght, M. D., assistant director at Rochester State Hospital, has been named acting medical inspector.

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McGILL ANNOUNCES FOUR-YEAR COURSE IN PSYCHIATRY

A four-year postgraduate course in psychiatry, leading to a diploma, is announced by McGill University, Montreal, with the primary purpose of preparing physicians for work in teaching, research, community and consulting fields. A degree from an approved medical school, a one-year general interneship and "satisfactory personal qualifications" are prerequisites for the course. The work will include experience in the Allan Memorial Institute of Psychiatry, on the wards and in the outpatient department of the Royal Victoria Hospital, and in community psychiatry. Part of the time is to be spent, says the university's announcement, "in dealing with long-term cases in designated mental hospitals;" and there will also be work in neurology and neuropathology.

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DR. ROBERT ELLIOTT DIES AT CANANDAIGUA

Robert Michael Elliott, M. D., superintendent of Willard State Hospital for 30 years before his retirement in 1934, died at his home in Canandaigua, N. Y., on October 5, 1945. He was more than 80 years old. Born in England in 1863, he came to America when he was 21, studying medicine at Buffalo University and being graduated from there in 1890. After joining the State hospital service that same year, Dr. Elliott served at Rochester and at the Brooklyn division of Long Island State Hospital, becoming medical superintendent of the division in 1895 and superintendent in 1900 when Brooklyn was established as a separate institution. In 1904, he transferred as superintendent to Willard.

Dr. Elliott was active in education and in community mental hygiene and after-care work. He lectured at Long Island Medical College for many years. His long service to Willard was commemorated in 1931 by the naming of a new reception building there in his honor.

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FORENSIC MEDICINE INSTITUTE IS PART OF NEW YORK UNIVERSITY-BELLEVUE PLANS

A project of particular interest to psychiatrists in the plans of New York University and Bellevue Hospital for a huge $27,500,000 medical center, for which the university is now seeking to raise $15,000,000 for its share in construction, will be an Institute of Forensic Medicine, long projected as a joint venture of the New York City medical examiner's office and the university. It will be the first institute of its kind in the country, will offer instruction in legal medicine and is expected to take an important part in the investigation of American medico-legal problems. The building, to be owned by the city and operated in partnership with the university, is expected to be built at 33d Street and First Avenue.

The university opened this fall a series of refresher and review courses for returning medical officers from the services. They include long-term courses for physicians whose postgraduate training was interrupted by the war before they could complete requirements for certification by specialty boards and special provisions for young physicians whose interneships and educations were shortened by wartime necessities and who need more training.

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DR. BOURKE DIRECTS SURVEY OF STATE'S HOSPITAL FACILITIES

Dr. John J. Bourke of Albany has been appointed director of the survey which is now under way for the Joint Hospital Board, recently appointed by Governor Dewey to determine New York's present hospital facilities and needs. Dr. Bourke is already familiar with the general situation, as he assisted in the survey made by the State Defense Council in 1941 to plan emergency service for civilians. He has just returned from a year's service in the Pacific as chief medical officer of a coast guard assault vessel. Commissioner Robert T. Landsdale of the State Department of Social Welfare is chairman of the Joint Hospital Board, and Commissioner Frederick MacCurdy, M. D., of the Department of Mental Hygiene is vice-chairman.

NEW PSYCHIATRIC CLINIC ESTABLISHED IN OHIO

Western Reserve University's School of Medicine in Cleveland, Ohio, has announced the establishment of new departments of psychiatry in the school and at University Hospitals, as well as the opening of a new psychiatric clinic which will treat service personnel and their families free of charge and civilians at nominal cost. The clinic will have five psychiatrists, a psychologist and a staff of social workers and nurses. The Red Cross is financing the free treatments for service men. Maj. Douglas D. Bond, M. C., chief of psychiatry in the office of the United States air surgeon in Washington, has been chosen to take the new chair of psychiatry in the medical school.

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B. R. TUCKER, M. D., PELLAGRA AUTHORITY, DIES AT 71

Dr. Beverley Randolph Tucker, neurologist and psychiatrist who was known internationally as a student of pellagra, died in the hospital he himself founded 30 years ago in Richmond, Va., on June 19, 1945, at the age of 71. Writing on pellagra more than 30 years ago, Dr. Tucker had advanced the theories that the characteristic skin and mucous membrane lesions were of neurologic origin and that the disease was caused by a virus. He wrote the section on pellagra of the "British Medical Annual" in 1914. Other writings in neurology included the section on cranial nerves in "Tice's System of Medicine," and he also wrote fiction and verse. In the psychiatric field, he was an early advocate of the point of view that conduct disturbances constituted medical problems.

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PSYCHOSOMATIC MEDICINE COURSES OFFERED FOR GENERAL PRACTITIONERS

A course in psychosomatic medicine for general practitioners and internists has been announced for next March by Temple University. It will be conducted by Dr. Edward Weiss, professor of clinical medicine, Dr. O. Spurgeon English, professor of psychiatry, and Dr. Gerald H. J. Pearson, associate professor of psychiatry, with associates and guest lecturers. The university announces that the course is "not intended for specialization in psychiatry," and that it will be open to a limited number of qualified physicians with the aim of assisting them in the diagnosis and management of psychoneurotic and psychosomatic problems. There will be lectures, seminars, conferences and clinical work.

DR. HARMS BUYS "THE NERVOUS CHILD"

"The Nervous Child," quarterly publication in the field of child psychopathology, psychotherapy, mental hygiene and guidance, has been bought from Grune & Stratton, publishers, by Dr. Ernest Harms, its editor-in-chief who also was its founder in 1941. A new publishing house, Child Care Publications, 30 West 58th Street, New York 19, N. Y., has been founded to produce the periodical. This same new concern will start to publish, during 1946, another periodical, "The Journal of Child Psychiatry." This will be devoted to unsolicited contributions on mental disorders in children. "The Nervous Child" has been largely devoted to special contributions in the nature of symposia from contributors on specified topics, with special coeditors assigned to each main subject.

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WINFRED OVERHOLSER, M. D., HEADS NEW PUBLICATION

Announcement of a new publication, "The Quarterly Review of Psychiatry and Neurology," with Winfred Overholser, M. D., as editor-in-chief, has been made by the Washington Institute of Medicine, Washington, D. C., which will publish it. It will be brought out in January, April, July and October, at an annual subscription rate of $9.00. Members of the editorial board are Spafford Ackerly, M. D., A. E. Bennett, M. D., Karl M. Bowman, M. D., Stanley Cobb, M. D., Frederic A. Gibbs, M. D., Edward J. Humphreys, M. D., Solomon Katzenelbogen, M. D., J. M. Nielson, M. D., Lewis J. Pollock, M. D., Tracy J. Putnam, M. D., Lauren H. Smith, M. D., and John C. Whitehorn, M. D.

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GENERAL SEMANTICS SEMINAR AND TRAINING COURSE

The Institute of General Semantics, Chicago, announces the dates of its winter-holidays course in fundamental orientation, principles and techniques as from December 27, 1945, through January 10, 1946, with the course divided into two parts, the first ending on January 2 for the benefit of those unable to spend two full weeks. The announcement indicates the sessions will be primarily for those "actively interested" in General Semantics methods and applications in a variety of fields among which "psychosomatic medicine, medical education, mental hygiene and group work in rehabilitation" are mentioned.

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